Marin Community Clinics

Patient Registration Form

PLACE STICKER HERE

DEMOGRAPHICS

Name of Patient: _____ _____ _____ _____ _____
Last First Middle * Previous Last Name * Previous First Name

Date of Birth: _____/_____/_____ Month / Day / Year

Gender Identity: ☐ Female ☐ Male ☐ Genderqueer, neither exclusively Male nor Female ☐ Female to Male (Transgender Male) ☐ Male to Female (Transgender Female) ☐ Chose to not disclose

Sex at Birth: ☐ Female ☐ Male

Sexual Orientation: ☐ Straight/Heterosexual ☐ Bisexual ☐ Lesbian, Gay or Homosexual ☐ Don't Know ☐ Something else, please describe: _____ ☐ Chose to not disclose

Preferred Pronouns: ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir ☐ Other: _____ ☐ Decline to State

Home Address: _____ Apt._____ City _____ State _____ Zip _____

Mailing Address: _____ Apt._____ City _____ State _____ Zip _____

What is the best way to contact you? ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text ☐ Alternate ☐ Confidential (**DO Not Call**)

Home # (____)_____-_____ **Cell #** (____)_____-_____ **Work #**(____)_____-_____ *Alternate # (____)_____-_____

Is it okay if we can contact you via? ☐ voice message ☐ text ☐ email *If alternate applies, whose phone number is this? _____

Email: _____@_____ *(email will add you to the patient portal)*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Widowed ☐ Legally Separated

Mother's Maiden Name: _____

Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Sign Language ☐ Other_____

Impairments and/or Disabilities: ☐ Visually Impaired ☐ Hearing Impaired **Translator Needed**: ☐ Yes ☐ No

RELATIONS/ROLE

FOR MINORS ONLY:

Parent/Legal Guardian of Minor: _____ Date of Birth: ____/____/_____ Relationship to minor _____

Parent/Legal Guardian of Minor: _____ Date of Birth: ____/____/_____ Relationship to minor _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone # (____)_____-_____

ADDITIONAL REQUIRED INFORMATION

* As a federally qualified health center we are required to collect this information. All information shared will remain confidential.

Homeless Status: ☐ No ☐ Doubling Up ☐ Shelter ☐ Street

Are you a farm worker? ☐ No ☐ A migrant worker (leave your community for work) ☐ Seasonal Worker (work on a seasonal basis within your home community)

Ethnicity: (Please check one, ONLY) ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to state

Race: (check all that apply)

☐ White ☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian ☐ More than one race
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Decline to state ☐ Unknown

Veteran Status: Are you a Veteran? ☐ Yes ☐ No

Family Size: _____ **Family Income**:_____

Name of Insurance: _____ **Insurance #**: _____

RESPONSIBLE PARTY (Guarantor)

Statement/bills will be addressed to responsible party.

Name: _____ Date of Birth _____/_____/_____ Email: _____@_____

Mailing Address _____ _____ Apt._____ City _____ State _____ Zip _____

Home Phone # (____)_____-_____ Cell # (____)_____-_____ Work Phone # (____)_____-_____

MARIN COMMUNITY CLINICS – GENERAL CLINICAL CONSENT

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services will be provided if needed.

Consent for Treatment: I request Marin Community Clinics (MCC) to provide me with health care services, including but not limited to medical care, dental care, behavioral health care and substance use services. I will be given information about the test(s), treatment(s), procedure(s), and medication(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand.

I understand the MCC strives to provide integrated care, which ensures all members of my care team have access to important health information needed for my care.

I hereby request that a person authorized by Marin Community Clinics provide appropriate evaluation, testing, and treatment. I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care.

Confidentiality agreement for group: Because group visits involve patients disclosing private medical and social information, all participants in a group visit – including the patient and any accompanying family members/friend – must agree to respect the privacy of ALL participants and keep their information confidential.

By signing this consent, I assume the responsibility for keeping all information confidential if I participate in shared medical visits/ groups.

Release of Information: I understand that confidentiality will be maintained as described in *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*. **I understand that all services are confidential. However in cases of life threatening emergencies and physical or sexual abuse, we may need to make a referral to another agency.**

Assignment of Insurance Benefit: I hereby authorize payment directly to MCC of benefits otherwise payable to me but not to exceed MCC's regular charges for this service. **I understand that I am financially responsible to MCC for any charges not covered by my insurance.**

Financial Agreement: I agree to pay all charges that are not payable by insurance or third party. I agree to abide by the terms and conditions of MCC's Collections Policy, and agree to pay for attorney fees or other expenses incurred in the collection of payment due.

In accordance with MCC's Collections Policy, MCC may choose to terminate its relationship with any patient who does not comply with this financial agreement.

Statement to Permit Payment of Medicare Insurance Benefits to MCC: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf.

Acceptance of Responsibility for Co-Payments: I understand that I am responsible for any health insurance deductibles or co-payments, including a twenty percent (20%) co-payment for authorized services covered by Medicare.

The undersigned certifies that I read and understood the information above and authorize services by Marin Community Clinics as the patient or as the patient's general agent and accepts its terms.

Print Name	Signature of Patient or Legal Guardian	Date Signed

Witness	Date Signed