MARIN CITY
Health & Wellness Center

PATIENT REGISTRATION FORMS

DATE:

PATIENT INFORMATION

Name First: _____ Last: _____ Suffix: _____

Other Name(s) Used: _____ Sex: ____ Male ____ Female ____ Transgender

Mailing Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ___ Married ___ Single ____ Widowed ____ Divorced ____ Separated ____ Partnered

Phone: (Home) (_____) _____ (Cell) (_____)_____

May we leave a message? ____ Brief ____ Extended Primary Language: _____

Date of Birth: _____/_____/_____ SS#: _____-_____-_____

Email: _____

Pharmacy: _____

RACE AND ETHNICITY

Race: (Please check all that apply)

- ☐ African American/Black
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Asian
- ☐ Caucasian/White
- ☐ Pacific Islander
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

INSURANCE INFORMATION

Employed: ____ Yes ____ No If yes, ____ Full Time ____ Part Time

Employer: _____

Employer Address: _____

Primary Insurance: _____

Insured Name: _____

Insured ID #:_____

Pt Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other

Student: ____ Yes ____ No If yes, ____ Full Time ____ Part Time

Emergency Contact: _____ Phone _____ Relationship_____

Responsible Party (If patient is a minor, please complete this section)

Name First: _____ Last: _____ Relationship_____

Address (If different) _____ City _____ State _____ Zip _____

Date of Birth: _____/_____/_____ SS# _____-_____-_____

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Thank you for answering the following questions which are required by the Health Resources and Services Administration.

We collect data to ensure that we can acquire funding to serve our community as a Federally Qualified Health Center and to recognize patients who may qualify for special programs or services. We only report population-level data, never individual information.

This information will be part of your CONFIDENTIAL medical record.

INCOME INFORMATION

How many people are in the patient's household: _____

Using the table below, which income category best reflects the patient's household income? _____

Number of Household Members	Category A	Category B	Category C	Category D
1	< $13,590	$13,591 - 20,385	$20,386 - 27,180	> $27,180
2	< $18,310	$18,311 - 27,465	$27,466 - 36,620	> $36,620
3	< $23,030	$23,031 - 34,545	$34,546 - 46,060	> $46,060
4	< $27,750	$27,751 - 41,625	$41,626 - 55,500	> $55,500
5	< $32,470	$32,471 - 48,705	$48,706 - 64,940	> $64,940
6	< $37,190	$37,191 - 55,785	$55,786 - 74,380	> $74,380
7	< $41,910	$41,911 - 62,865	$62,866 - 83,820	> $83,820
8	< $46,630	$46,6318 - 69,945	$69,946 - 93,260	> $93,260

EMPLOYMENT INFORMATION

What type of work does the patient do?

- ☐ Professional
- ☐ Clerical
- ☐ Sales
- ☐ Service
- ☐ Laborer
- ☐ Agriculture
- ☐ Other

If Year Round Agricultural, please check if:

- ☐ Migrant
- ☐ Seasonal

HOUSING INFORMATION

___ YES	____ NO	Is your name on a signed lease agreement?
___ YES	____ NO	Do you live in temporary housing?
___ YES	____ NO	Do you live with a relative, friend, or significant other?
___ YES	____ NO	Do you live in a shelter?
___ YES	____ NO	Are you doubling up?
___ YES	____ NO	Do you live in Public Housing?
___ YES	____ NO	Are you homeless?

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_____ **PAYMENT POLICY:** Regarding ***Medi-Cal and/or Medicare*** please provide us with your current card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service. ***Private insurance*** please provide us with a copy of your insurance card at each visit, all co-pays and deductibles are due at the time of service. ***Private Pay*** patients full amount us due at the time of service. We accept CASH, CHECKS, and CREDIT CARDS. We offer a Sliding Fee discount if you qualify. Please ask a receptionist for additional information. All sliding fee program co-pays are expected at the time of service. We offer different ***government funded*** programs in which you may qualify. If you would like more information, please ask our receptionist. We depend on your prompt payment for services so that we can continue to provide quality, low-cost care for our community. Thank you for choosing us as your health care provider.

_____ **CONSENT:** In order to provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initializing the areas indicated and by providing your signature below.

_____ **ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT:** I authorize payment of medical benefits to Marin City Health and Wellness Center (MCHWC) for professional services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees.

_____ **RELEASE OF INFORMATION:** I authorize release of all information necessary to secure the payment of benefits related to my care. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ **CONSENT OF TREATMENT:** I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself and my family while a patient at MCHWC.

Your signature below indicates you have read, understand, and agree to the payment policy and consents. This agreement will remain in effect until revoked by the patient in writing.

Patient Signature _____ Print Name _____ Date_____

NOTICE OF PRIVACY PRACTICES: Marin City Health and Wellness Center is committed to protecting your personal health information in compliance with the law. The Notice of Privacy States: (A copy will be given upon request)

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in this Notice
- The person to contact for further information about our privacy practices.
- I hereby acknowledge that I have received/been offered a copy of the Notice of Privacy Practices.

Patient Signature _____ Parent (If Minor) _____ Date_____

MEDICARE SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on my behalf to MCHWC for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the health care financial administration and its agents any information needed to determine these benefits payable to related services. I understand my signature below requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated or the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature _____ Print Name _____ Date_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F ☐ T
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **DOB:** _____	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
List any medical problems that other doctors have diagnosed		
Have you ever had a blood transfusion?	☐ Yes	☐ No

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ High	☐ Med	☐ Low	
	Rank fat intake	☐ High	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuses have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

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MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestine	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

How did you hear about us? (Please check all that apply)

- ☐ Referred by friend or family member
- ☐ Assigned by health plan
- ☐ Referred by other organization
- ☐ Attended an event held by clinic
- ☐ Online
- ☐ Other (please specify): _____

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Late Policy

- In order to best serve patient and community needs we have a policy regarding late arrival/late cancellation and failure to appear for medical appointments. Due to the high demand for appointments, we must adhere to the following:

- If you are late for your appointment, it will be considered a failure to appear and you will be rescheduled.

- An appointment cancelled less than 24 hours in advance is considered as a failure to appear. If you need to miss an appointment, please do us the courtesy of notifying the office 24 hours in advance.

- If you repeatedly fail to make your appointment you will be placed on a wait list rather than be rescheduled.

We reserve time for your treatment and respect your schedule. Thank you for your patronage and cooperation.

_____	_____	_____
Patient Name	Signature	Date

Notice Regarding Advance Directives

Advance Directives are written instructions which communicate your wishes about the care and treatment you want if you reach a point where you can no longer make your own health care decisions.

All Healthcare facilities are required by the state of California to provide patients with written information concerning 1) their right to accept or refuse treatment and 2) their right to prepare advance directives. The law does not require that you actually have or make an advance directive.

If you have an Advance Directive, your healthcare provider must be provided with a copy to ensure that your wishes are understood.

****

Please complete the following:

1. Do you have an Advance Directive? _____ Yes _____ No

   If yes, have you provided a copy to your provider for their records? _____ Yes _____ No

2. Would you like to receive information regarding Advance Directives? _____ Yes _____ No

_____ _____ _____

Patient Name Signature Date

PATIENT RULES AND RESPONSIBILITIES

MARIN CITY
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A patient who receives care through The Marin City Health and Wellness Center has the following responsibilities:

1. Respect the policies and guidelines of The Marin City Health and Wellness Center.

2. Be respectful of all health care providers and staff, as well as other patients.

3. Provide complete and accurate information to the best of his/her ability about his/her health, any medications including over the counter products, dietary supplements and any allergies or sensitivities.

4. To keep appointments and be on time. If the appointment cannot be kept, the patient should notify the staff as soon as possible to cancel the appointment and/or to reschedule.

5. The patient has the responsibility to carefully follow the health care provider's instructions, treatment plan, and to take medications as directed.

6. The patient has the right to refuse treatment, but the patient may not dictate treatment.

7. The patient is responsible for communicating any negative changes, side effects, or failed improvement following treatment within a reasonable period of time.

8. It is the patient's responsibility to provide an up to date, valid phone number, update all contact information and insurance information.

9. If a patient presents to the clinic intoxicated or high, they will be asked to leave and reschedule.

10. A patient who arrives late for their appointment may be rescheduled to another date and/or time.

_____ _____ _____

Patient Name Signature Date