MONOCACY HEALTH PARTNERS

PATIENT REGISTRATION FORM

PATIENT

NAME (First, Middle, Last) | DATE OF BIRTH | BIRTH SEX ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED

STREET ADDRESS OR MAILING ADDRESS (PO BOX) | CELL PHONE NUMBER | PRIMARY PHONE NUMBER

CITY STATE ZIP CODE | E-MAIL (Required for Patient Portal) | WORK PHONE NUMBER

EMPLOYER

EMPLOYMENT STATUS
☐ Full Time ☐ Part Time ☐ Self-Employed
☐ Unemployed ☐ Retired ☐ Active Duty

STUDENT STATUS
☐ Full Time ☐ Part Time ☐ Not Student

PRIMARY CARE PROVIDER

PRIMARY LANGUAGE | SOCIAL SECURITY #

MARITAL STATUS
☐ Single ☐ Married ☐ Separated
☐ Annulled ☐ Widowed ☐ Divorced
☐ Domestic Partner ☐ Interlocutory
☐ Life Partner ☐ Polygamous ☐ Unknown

PREFERRED CONTACT METHOD
(Check all that apply)
☐ Home Address(letters)
☐ Home Phone ☐ Cell Phone

RACE
☐ American Indian/Alaskan Native ☐ White/Caucasian ☐ Black
☐ Multiracial ☐ Asian/Pacific Islander ☐ Refused/undetermined

ETHNICITY
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Refused or Undetermined

CURRENT GENDER
☐ Female ☐ Male ☐ Undifferentiated

PREFERRED PRONOUN
☐ Choose not to disclose
☐ Decline to Answer ☐ She, Her, Hers
☐ He, Him, His ☐ Ze, Hir
☐ They, Them, Theirs ☐ Other

SEXUAL ORIENTATION
☐ Choose not to disclose
☐ Straight or Heterosexual
☐ Bisexual
☐ Don't Know
☐ Lesbian, gay or homosexual
☐ Something else, please describe

GENDER IDENTITY
☐ Choose not to disclose
☐ Additional gender category or other, please specify
☐ Female
☐ Female-to-Male(FTM)/Transgender Male/Trans Man
☐ Genderqueer, neither exclusively Male nor Female
☐ Male
☐ Male-to-Female(MTF)/Transgender Female/Trans Woman

RESPONSIBLE PARTY

NAME (First, Middle, Last) | DATE OF BIRTH | SEX ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED

ADDRESS | TELEPHONE – HOME | TELEPHONE - WORK

RELATIONSHIP TO PATIENT
☐ Parent ☐ Guardian ☐ Other

EMPLOYER

PRIMARY INSURANCE CARRIER

INSURANCE CARRIER NAME-

INSURANCE ID# ***See card*** GROUP # ***See card***

SUBSCRIBER (POLICY HOLDER)

NAME _____ Birthdate_____

ADDRESS _____ Phone_____

PATIENT-SUBSCRIBER RELATIONSHIP
☐Self ☐Spouse ☐Dependent ☐Other

SECONDARY INSURANCE CARRIER

INSURANCE CARRIER NAME-

INSURANCE ID # ***See card*** GROUP # ***See card***

SUBSCRIBER (POLICY HOLDER)

NAME _____Birthdate_____

ADDRESS _____Phone_____

PATIENT-SUBSCRIBER RELATIONSHIP
☐Self ☐Spouse ☐Dependent ☐Other

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

NAME | DAYTIME TELEPHONE | EVENING TELEPHONE

If you are here for an injury, is it: ☐ Work Related ☐ Auto Related ☐Neither

ALL PAYMENT DUE AT TIME OF SERVICE

I authorize payment of insurance benefits directly to Monocacy Health Partners. Payment is due upon receipt of services. I will be responsible for fees and charges according to Monocacy Health Partners and my health plan. If I do not provide a VALID insurance card at each visit, I will be held responsible for services and asked to sign a waiver. If the account were to be referred to a collection agency, I will pay all fees and collection expenses. I understand that I may be contacted by Monocacy Health Partners and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages, and/or an automatic dialing device ("auto dialer"), by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

Patient Signature: _____ Date: _____
Or
Patient Representative_____ Relationship to Patient: _____