MLK Community Medical Group

Patient Name: ______________________

Date of Birth: ______________________

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: ____
Last First Middle

Date of Birth: ______________ Sex: __________ Driver's Lic #: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Race: ______________________ Ethnicity: ______________________

Mailing Address: ____

City: ______________________ State: _______ Zip: __________

I'd like to receive appointment and clinical reminders via text. ☐ Yes ☐ No Cell #______________

Preferred Telephone # for Routine Communication: ______________ ☐ Home ☐ Work ☐ Cell

Secondary Phone: ______________ ☐ Home ☐ Work ☐ Cell

E-mail: ______________________ Primary Spoken Language: ______________

Primary Care Provider: ______________________ How were you referred? ______________

Employer: ______________________ Employer Phone: ______________

Work Address: ______________________ City: ______________ State: _______ Zip: __________

EMERGENCY CONTACT

If patient is a child, please provide an emergency contact other than a parent/guardian.

Contact Name: ______________________ Relation to Patient: ______________

Address (Street or PO Box): ____

City: ______________________ State: _______ Zip: __________

Home Phone: (_____) ______________ Work Phone: (_____) ______________ Cell Phone: (_____) ______________

PRIMARY RESPONSIBLE PARTY

☐ I am Responsible Party ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ______________

Name: ____
Last First Middle

Date of Birth: ______________________ Sex: ______________

Street Address: ____

City: ______________________ State: _______ Zip: __________

Phone: ______________________ Driver's Lic #: ______________

Employer: ______________________ Employer Phone: ______________

Work Address: ______________________ City: ______________ State: _______ Zip: __________

SECONDARY RESPONSIBLE PARTY

Name: ______________________ ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ______________

Employer: ______________________ Employer Phone: ______________

Work Address: ______________________ City: ______________ State: _______ Zip: __________

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NEW PATIENT REGISTRATION FORM

*RACE AND ETHNICITY

Identify Race: We are required by Federal health care programs to request this information as a part of the demographic data they collect. Individuals are asked to indicate one or more races that apply from among the following or you may decline to specify.	
American Indian or Alaska Native Asian Black or African American	**Native Hawaiian or Other Pacific Islander White**
Race Categories as defined by US Federal OMB:	
American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
Black or African American	A person having origins in any of the black racial groups of Africa.
Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
Identify Ethnicity: We are required by Federal health care programs to request this information as a part of the demographic data they collect. Individuals are asked to designate their ethnicity from the following or you may decline to specify:	
Hispanic or Latino; or	**Not Hispanic or Latino**
Hispanic or Latino defined	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin regardless of race.
Unknown	Unknown/Not Reported

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NEW PATIENT REGISTRATION FORM

INSURANCE INFORMATION

Primary Insurance

Company Name: ______________________________

Subscriber's Name: ______________________________ Date of Birth: ______________________________

Relation to Patient: ______________________________

Subscriber's Address (if other than patient): ______________________________

Secondary Insurance

Company Name: ______________________________

Subscriber's Name: ______________________________ Date of Birth: ______________________________

Relation to Patient: ______________________________

Subscriber's Address (if other than patient): ______________________________

ELIGIBILITY GUARANTEE

I hereby certify that I am eligible with the health insurance company under the subscriber indicated on my registration sheet. I also certify that I have chosen Martin Luther King Community Medical Group to provide healthcare services. I understand that if the above is not true or I am not eligible under the terms of my medical and hospital subscriber agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill.

Signature: ______________________________ Date: ______________________________

COMMUNICATION CONSENT

By providing the Martin Luther King Community Medical Group or its service providers with a telephone number for a cellular or other wireless device and/or an e-mail, I agree that Martin Luther King Community Medical Group or its service providers may use the provided telephone number or e-mail to service my account(s) (including contacting me about obtaining potential financial assistance for my account(s)), to send the patient appointment and follow-up health care reminders by text or e-mail, to send me information, to schedule patient appointments, and to collect any amounts I may owe to my healthcare provider(s). I understand and agree that Martin Luther King Community Medical Group and its agents, representatives, or other service providers as well their respective agents and contractors, including any billing or account management companies and/or debt collectors may contact me at the provided telephone number(s) which could result in charges to me. I expressly consent that methods of contact may include using pre-recorded and artificial voice messages, text, email, (if an email address has been provided) and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with my account number(s) and is not a condition of purchasing property, goods, or services. I am not required to sign this consent as a condition of receiving healthcare services.

______________ Initials / Approve ______________ Initials / Decline

AUTHORIZATION FOR RELEASE OF MEDIAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize and request the insurance company(s), or agent thereof, to pay directly to Martin Luther King Community Medical Group for services provided to me by Martin Luther King Community Medical Group. I am aware that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. This signature will also serve as an authorization to release medical information necessary to satisfy payment.

______________________________ ______________________________

Signature of Patient (if minor, Signature of Responsible Party) Date

______________________________ ______________________________

Signature of Guardian or Personal Representative Date

______________________________ ______________________________

Print Name of Guardian or Personal Representative (print) Relationship to Patient