



PATIENT REGISTRATION FORM

(For office use only) Date _____ Account # _____ Chart # _____

WHO IS THE PATIENT? Please Print

Patient's Last Name _____ First Name _____ Middle _____
Address _____ City/State _____ Zip _____
Home Telephone (_____) _____ Patient's Work Telephone (_____) _____
Patient's Social Security No. _____ Patient's Date of Birth _____
Race: [] White [] Black [] Hispanic [] Asian [] Other _____
Patient's Marital Status: [] Single [] Married [] Divorced [] Widowed [] Other _____
Gender: [] Male [] Female

IMPORTANT: Has the patient or any family member ever been to this clinic before? YES NO

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
Emergency contact phone number MUST be DIFFERENT from above numbers: (_____) _____

RESPONSIBLE PARTY

Name of Parent/Guardian _____ Relationship to Patient _____
Date of Birth _____ Social Security # _____
Marital Status: [] Single [] Married [] Divorced [] Widowed [] Other
Place of Employment _____ Work Phone Number (_____) _____
Address _____ City/State/Zip _____

INSURANCE INFORMATION

Patient's MEDICAID number _____ Patient's MEDICARE number _____
Insured Person's Name _____ Insured Persons Date of Birth _____
Insured Person's Telephone Number (_____) _____ Primary Care Provider (if HMO) _____
Name of Insurance Carrier _____ ID# _____ Group # _____
Insured Person's Employer _____ Work Address _____
Relationship of Insured Person to Patient: [] Self [] Spouse [] Son/Daughter [] Other



MLK, JR. Family Clinic

2922 – B MLK, Jr. Blvd., Dallas, TX 75215

FAMILY INFORMATION

List all immediate family members living in the household including yourself:

Name	Date of Birth	Relationship to Patient	Insurance Carrier
1 Patient		Self	
2			
3			
4			
5			
6			
7			

FINANCIAL INFORMATION and FEES You may be eligible for a discount on your clinic fees. If you would like to be considered for a possible discount, we will need to collect household income information. You will need to provide proof of income such as W2 Forms or check stubs. All of this information is confidential.

Name of family member	Gross income
	\$
	\$
	\$

Circle one that applies:
 Paid weekly x 52
 Paid every 2 weeks x26
 Paid twice monthly x 24
 Paid monthly x12

Total Gross Income for Household \$

FOR OFFICE USE ONLY:



Consent for Treatment of an Adult

Name of patient: _____ Date of Birth ____/____/____

Name of person giving consent is different from patient:

(Print name) _____

Relationship to patient: Self Parent Guardian Other _____

I hereby and voluntarily consent to authorize the physicians, midlevel providers (Physician Assistant, Advance Practice Nurse) and dentists, if available, on MLK, Jr. Family Clinic staff at their service locations to provide health care services to me. The health care services may include routine physical and mental assessment, diagnostic and monitoring tests and procedures, examinations and medical and/or dental treatment, if available. The health care services may include, but are not limited to, routine laboratory work, such as blood, urine and other studies, x-rays and other imaging studies, heart tracing (EKG), administration of medications, as well as procedures and treatment prescribed by the medical and/or dental staff. The health care services also may include counseling services necessary to receive appropriate services including family planning services as defined by federal regulation.

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and will receive a Vaccine Information Statement (VIS) for each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there are no guarantees being made to me concerning the results of the treatment provided or the effectiveness of any birth control methods prescribed for me.

I have received the *Patient and Center Rights and Responsibilities* and the *Notice of Patients Privacy Rights* and understand my rights as stated in those documents.

I certify that I fully understand this consent for treatment, use of midlevel providers, release of personal health information and my rights concerning these issues.

I understand that this consent is valid and remains in effect as long as I am a patient of MLK, Jr. Family Clinic.

I have been given an opportunity to ask questions about the services to be provided by this Center and I believe that I have sufficient information to give this consent.

Signature of Patient/Agent

Witness

Print Name

Print Name

Date

Time

Date

Time

*Translated into _____/Read to person consenting by:

Signature

Print Name

Date

Time