



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



Consent for Treatment on Behalf of a Minor*

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

* A minor is an individual who is under 18 years of age who is not and has not been married or had the disabilities of minority removed by the court.

I am authorized to consent on behalf of the above minor as I am the minor's

parent or _____
State relationship to minor that grants authority

I _____ hereby and voluntarily consent to authorize the
Print the name of parent or legally authorized person

physicians, mid-level 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 the above minor. 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. I understand that family planning services for minors funded by Title V and Title XX require a separate parental consent form.

I have received the Patient and Center Rights and Responsibilities and the Notice of Patients Privacy Rights and understand those documents. I certify that I fully understand this consent for treatment, use of midlevel providers, release of personal health information and the minor's rights concerning these issues. I understand that this consent is valid and remains in effect as long as the minor is 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.

I hereby delegate authority to consent to treatment for the above minor to
*(Print name) _____ for the period of ____/____/____ through ____/____/____.

*The individual delegated to give authority and receive authority for consent of treatment to minors must be 18 years of age or older.

Signature of Parent or Legal guardian

Witness

Print Name

Print Name

Date Time

Date Time

*Translated into _____/Read to person consenting by:

Signature

Print Name

Date Time