

CLIENT REGISTRATION FORM

Please complete this form so we can provide the best care possible. The information you share with us is part of your **confidential** medical record. Some infectious diseases must be reported to the Indiana State Department of Health in accordance with Indiana state law (IC 16-41-2-1).

FOR STAFF USE ONLY

MCHD Client # _____ Wishard Patient # _____

Location, School or Screening Event _____

PLEASE PRINT

Date of birth: ____ / ____ / ____
MM DD YYYY

Social Security number: ____ - ____ - ____

Name: _____
First Middle Last

Nickname: _____ Maiden: _____

Address: _____
Street address City State Zip Code

Home phone: () - _____ Work Phone: () - _____ Cell phone: () - _____

Is the patient of a multiple birth? (twin, triplet, etc.) Check the box if the answer is Yes.

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Please answer both questions: Please select all that apply. <i>(This information is for statistical use only)</i>		
1. What is this person's race?		
<input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaskan Native - Specify tribe: _____ <input type="checkbox"/> Asian Indian	<input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Hawaiian Native <input type="checkbox"/> Japanese <input type="checkbox"/> Korean	<input type="checkbox"/> Other Asian: _____ <input type="checkbox"/> Other Pacific Islander: _____ <input type="checkbox"/> Other Race: _____ <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White
2. Is this client Spanish/ Hispanic/ Latino?		
<input type="checkbox"/> No, not Spanish/ Hispanic/ Latino <input type="checkbox"/> Yes, Mexican, Mexican Am., Chicano	<input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban	<input type="checkbox"/> Yes, other Spanish/ Hispanic/ Latino - Specify: _____

Insurance Information: Medicaid/Hoosier Health Wise ID # _____
Dental Insurance Company: _____ ID # _____ Subscriber # _____
Wishard Advantage ID # _____

May we contact you at the address and phone number listed above? Yes No

If answer is no, please give contact address: _____

Contact phone number: () - _____

Parent or guardian information (if under age 18)

Name: _____ Date of birth: ____ / ____ / ____ Relationship: _____
MM DD YYYY

Address: _____ Phone Number: () - _____

In case of emergency who should be contacted?

Name: _____ Phone Number: () - _____

Authorization for services

I hereby authorize the Marion County Health Department to examine, test or provide services to the patient listed above. Test results and treatment will be explained to me as part of my visit today. If follow-up is needed on any test/exam results, I will be contacted by a staff member.

Patient/Parent/Guardian signature: _____ Date: _____

Acknowledgement of receipt of Notice of Privacy

I have received a copy of this office's Notice of Privacy Practices. *(You may refuse to sign this acknowledgement)*

Patient/Parent/Guardian signature: _____ Date: _____

HIPAA Refusal: Please complete if client refuses to sign the acknowledgement section. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____

Authorized Employee Name (Print) _____

Title (Print) _____

Employee Signature _____

Date _____



