MIDTOWN HEALTH CENTER

Section I: Patient Information

Last Name: _____ First Name _____ Middle Initial: _____

Social Security No.: _____ Date of Birth: _____ Sex assigned at birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone No.: _____ Cell Phone No.: _____ Alt. Phone No.: _____

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Child

Please select one answer per question and provide additional information when required:

Interpreter needed? ☐ Yes ☐ No Language: ☐ English ☐ Spanish ☐ Other

Are you a student? ☐ Yes ☐ No Student Status: ☐ Full time ☐ Part time

Are you a Veteran? ☐ Yes ☐ No

Are you a migrant farm worker? ☐ Yes ☐ No ☐ Seasonal

Transportation needed? ☐ Yes ☐ No

Select one: ☐ Not Hispanic ☐ Chicano ☐ Cuban ☐ Mexican ☐ Mexican American Other Hispanic ☐ Puerto Rican ☐ Choose not to disclose

Please check which of the following best describes your gender identity:

☐ Male ☐ Transgender male/female to male ☐ Transgender female/male to female

☐ Female ☐ Other ☐ Gender queer ☐ Choose not to disclose

Please check which of the following best describes your sexual orientation:

☐ Straight/Heterosexual ☐ Lesbian, gay, or homosexual ☐ Don't know ☐ Choose not to disclose

☐ Bisexual ☐ Other

Please check which of the following best describes your current housing. Please select only one:

☐ Home Owner / Renting ☐ Homeless shelter ☐ Transitional housing ☐ Unknown, choose not to disclose

☐ Living on the streets ☐ Public housing ☐ "Doubling up" with family/friends ☐ Treatment facility / incarcerated

Please check with of the following best describes your race. Please select only one:

☐ White ☐ Asian Indian ☐ Native Hawaiian ☐ Pacific Islander

☐ Black or African American ☐ American Indian or Native Alaskan ☐ More than one race ☐ Guamanian or Chamorro

☐ Chinese ☐ Filipino ☐ Japanese ☐ Samoan

☐ Vietnamese ☐ Korean ☐ Other Asian ☐ Unknown, not listed or choose not to disclose

Emergency Contact / Release of Information

Name: _____ Relationship to Patient: _____

Phone No.: _____ Alt. Phone No.: _____

Is the above contact also approved to receive your health care information? ☐ **Yes** ☐ **No**

Would you like any other individuals to receive your health care information?

Name: _____ Relationship: _____ Phone No. _____

Name: _____ Relationship: _____ Phone No. _____

I authorize Midtown Health Center to disclose my health care information and to discuss my health care needs to those that I above designate. I authorize the release of my billing information and give these individuals the ability to pick up prescriptions and medications on my behalf. These individuals will be considered by emergency contacts. Without authorization, no information may be shared.

Patient Name: _____ Responsible Party Signature _____ Date _____

Section II: Household Size and Income

Number of individuals in Household:_____

Total Annual Household Income*: $_____

☐ *I am a Midtown Health Center Employee

☐ I do not wish to apply for a sliding fee scale if eligible for payment discounting.

For reporting purposes, income must be greater than $0. Any income listed as $0 will be modified to the minimum of $1.00

Section III: POLICYHOLDER Insurance Information:

Do you have the following coverage? ☐ **Medical** ☐ **Dental** ☐ **None**

In order to bill your insurance for services, you MUST provide a copy of your insurance card(s).

Medical

Insurance Carrier: _____ POLICYHOLDER Date of Birth: _____

Policyholder

Last Name: _____ First Name: _____ Middle Initial _____

Policyholder Policy/Group No.: _____ ID No. _____

Policyholder Social Security No.: _____ Policyholder's Phone No.: _____

Policyholder's Mailing Address _____

Street *City* *ST* *Zip Code*

Dental

Insurance Carrier: _____ POLICYHOLDER Date of Birth: _____

POLICYHOLDER

Last Name: _____ First Name: _____ Middle Initial: _____

Policyholder Policy/Group No.: _____ ID No. _____

Policyholder Social Security No.: _____ Policyholder's Phone No.: _____

Policyholder's Mailing Address _____

Street *City* *ST* *Zip code*

Secondary Insurance

Insurance Carrier: _____ POLICYHOLDER Date of Birth: _____

POLICYHOLDER

Last Name: _____ First Name: _____ Middle Initial: _____

Policyholder Policy/Group No.: _____ ID No. _____

Policyholder Social Security No.: _____ Policyholder's Phone No.: _____

Policyholder's Mailing Address _____

Street *City* *ST* *Zip code*

Section IV: Responsible Party

Complete this section if patient is under 19 or if patient is not the financially responsible party

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient _____ Birthdate _____ Social Security No: _____

Address: _____ City: _____ ST: _____ Zip Code: _____

Home Phone No.: _____ Cell No.: _____ Alt. Phone No.: _____

Email: _____ Primary Language _____

Employer: _____

Street *City* *ST* *Zip Code*

MIDTOWN HEALTH CENTER

Consent for Diagnosis and Treatment

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the center. I understand that I will be asked to sign specific consent for surgical or other special procedures including general and or extensive local anesthesia. I am also aware that health services are not based on an exact science, and I acknowledge that no guarantees have been made to me as to the results of any of the treatment services. I hereby authorize Midtown Health Center to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimen or tissue taken from my body during my treatment.

My signature below indicates that in accordance with HIPAA, I am aware of Midtown Health Center's Privacy Policy, Patient Rights and Responsibilities, and Financial Policies are available to me upon my request.

I voluntarily request consent and authorize my attending provider, their associates, assistants, behavioral health clinician, or other practitioners under their orders to attend to myself, my minor child, or my ward at Midtown Health Center. I further authorize my providers to deliver medical and surgical treatment or HIV testing, including, but not limited to diagnostic procedures, x-rays and administration of medications, as is deemed necessary and advisable within the boundaries of the clinic has provided services.

Print Name	*Signature* *(Sign at Clinic)*	*Date*

Financial Consent for Services

My signature indicates that I assign any payment from my insurance carriers to be paid directly to Midtown Health Center. I understand that the billing of any secondary insurance is my responsibility. I understand that I am financially responsible for all charges whether or not paid by insurance.

As a condition of my treatment, I understand that insurance co-pays and nominal fees are expected on the day of service unless financial arrangements have been made in advance of services. This clinic depends upon reimbursement from its patients for the costs incurred for services rendered.

All dental services performed without previous financial arrangements, must be paid in full at the time of service. Patients who carry dental insurance understand that this clinic estimates coverage for dental services. The estimated portion is due at the time of service and these estimates are subject to change based on insurance coverage.

Print Name	*Signature* *(Sign at Clinic)*	*Date*