

PATIENT REGISTRATION

Last Name First Name Middle Initial Race

SSN Driver's Lic# Birth Date Age Gender (M/F)

Mailing Address: _____ Home Address: _____

Home Phone: _____ Day Phone: _____ Cell Phone: _____

E-Mail Address _____

How should we contact you for Preventive Care Reminders? _____

EMERGENCY INFORMATION:

Emergency Contact Name Relationship Phone #

Spouse/Parent/Guardian's Name Address if different Phone #

EMPLOYMENT INFORMATION:

Employer

Address Phone #

Spouses Employer

Address Phone #

How did you hear about our clinic? _____

NATIVE AMERICAN PATIENTS PLEASE PROVIDE US WITH YOUR TRIBAL AFFILIATION OR ENROLLMENT PAPERWORK. IF YOU DO NOT HAVE THIS INFORMATION, PLEASE ADVISE THE RECEPTIONIST

CONTINUED ON REVERSE

Please note ALL questions must be answered in order to serve you better.

PATIENT REGISTRATION

PRIMARY INSURANCE INFORMATION:

Name of Insured	Date of Birth	Your relationship to Insured
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Insurance Carrier	ID#	Group #
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Insurance Mailing Address SECONDARY

INSURANCE INFORMATION:

Name of Insured	Date of Birth	Your relationship to Insured
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Insurance Carrier	ID#	Group #
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Insurance Mailing Address

**Authorization to release information for billing purposes and assignment of payment benefits
to Mathiesen Memorial Health Clinic (MMHC)**

I, the undersigned, am requesting health care services from the personnel at MMHC. I consent to exams, tests, immunizations, and treatment felt necessary for my health. I hereby authorize the release of any information, including diagnosis of medical condition, for the purpose of payment by my insurance carrier. I affirm that the statements are true and correct to the best of my knowledge. I understand that in the event the insurance information is not complete and correct, or if my insurance carrier fails to make payment, I will be financially responsible for services rendered. I authorize the release of any information required by my insurance company to process any claims. I further authorized assignment of all insurance benefits directly to MMHC.

Signature of Patient/Parent/Guardian

Date

PATIENT REGISTRATION

WELCOME

To Mathiesen Memorial Health Clinic

This is our self administered health history form.

Thanks for taking time to fill this out. It goes into the computer as part of your record and can protect you from drug interactions and other kinds of harm.

What is the main reason you are looking for a Medical Provider.

Recent or important past Medical Providers

Overall what are your chronic ongoing medical issues, like back pain, diabetes, contraception, etc?

Chronic and ongoing Medical issues	When, how it started?, comments
1.	
2.	
3.	
4.	
5.	
For additional chronic medical issues see back of page	

Are you currently or have you in the past seen a Behavioral Health Professional Yes ___ No ___	
Behavioral Health Providers Name & Number	Medication prescribed by this provider
1.	1.
2.	2.
3.	3.

Do you have past health issues that have been resolved?

Past Medical Issues	How resolved, comments
1.	
2.	
3.	
For additional past medical issues see back of page	

ALLERGIES	What Happened? Allergic/Adverse/Bad Reaction
1.	
2.	
3.	
For additional past medical issues see back of page	

