REGISTRATION FORM

(Please Print)

PATIENT INFORMATION (Please give your identification to the receptionist)					
Patient's Last name:	First:	Middle Initial:	Marital status (circle one) Single / Mar / Div / Sep / Widow		
Have you been a patient here before? ❑ Yes ❑ No	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:	Social Security no.:	Home phone no.: ( )			
P.O. Box:	City:	State:	ZIP Code:		

INSURANCE INFORMATION & ID VERIFICATION (Please give your insurance card & driver's license to the receptionist)	
Are you covered by insurance? ❑ Yes ❑ No	Insurance Number:
Insurance Plan	❑ Private Insurance ❑ TennCare ❑ Medicare ❑ Other

MONTHLY HOUSEHOLD INCOME	
What is your monthly income $________________________ (Mandatory)	Number of People who live in your house?

DEMOGRAPHIC INFORMATION				
School Based? ❑ Yes ❑ No	Migrant Farm Worker? ❑ Yes ❑ No	Homeless? ❑ Yes ❑ No	Veteran? ❑ Yes ❑ No	Are You Hispanic or Latino? ❑ Yes ❑ No
Do you only speak English? ❑ Yes ❑ No	Do you need a translator? ❑ Yes ❑ No	What is your race? ❑ Asian ❑ African-American ❑ White ❑ American Indian ❑ Native Hawaiian ❑More than one race ❑Refuse to Report		

RESPONSIBLE PARTY (Please complete for all patients under 18 years old)			
Last Name, First Name	Relationship to patient:	Social Security #	Birth Date

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Alternate phone no.: ( )

DO YOU HAVE A LIVING WILL? ❑ **YES** ❑ **NO**
If you do not have a living will, you may ask our staff for information on this important subject.

CONSENT TO TREAT

The preceding information is true to the best of my knowledge. I request Matthew Walker Comprehensive Health Center, Inc. to provide me and/or my family member with medical, dental and/or diagnostic treatment. I understand that there is no guarantee or assurance as to the results of any treatment provided. I acknowledge my responsibility to pay for this care according to the fees established. I authorize assignment of benefits for medical, dental and or/diagnostic care and the services associated with my visit to be paid to Matthew Walker Comprehensive Health Center, Inc. I understand that I will be responsible for any fees that are not paid by my Insurer. I also agree that if I do not have any insurance that I will be responsible for my fees. I agree that I have been provided information regarding advanced directives, living will, durable power of attorney and the notice of privacy practices.

Patient/Guardian signature *Date*