PATIENT REGISTRATION– Page 1 of 2

REV. 2-5-2025 kdt

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:** _____
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS:_____
(STREET / PO BOX) (CITY) (STATE) (ZIP)

PHONE:_____/_____/_____
Circle the preferred Number: (HOME) (CELL) (WORK)

E-MAIL ADDRESS:_____ **SOCIAL SECURITY #**_____

PREFERRED METHOD OF CONTACT: (check one) Phone_____, Email_____, Postal Mail_____

GENDER: Male_____ Female_____ **MARITAL STATUS:** Single___ Married___ Widowed___ Divorced___

PATIENT / GUARDIAN EMPLOYER_____**PHONE #**_____

FOR PATIENTS THAT ARE 18 YEARS OR OLDER DO YOU HAVE A Power of Attorney: This is an individual appointed by you, your family or the court to make health care decisions for you, if you are unable to do so yourself. Do you have a Power of Attorney? NO_____ YES_____ If yes, name of individual:_____

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE: No _____ Yes____ If yes: copy provided _____

LIST SOMEONE TO CONTACT IN CASE OF AN EMERGENCY OR IF WE NEED TO REACH YOU:
Name:_____ Phone# _____

IF THE PATIENT IS UNDER THE AGE OF 18, PLEASE LIST BOTH PARENTS NAMES, ADDRESS , DATE OF BIRTH & PHONE NUMBER:
Father: _____ **Mother:**_____

PATIENT INSURANCE

IF PATIENT HAS ANY INSURANCE, MEDICARE OR MEDICAID THAT COVERS YOUR MEDICAL CARE, WE MUST MAKE A COPY OF THE CARD IN ORDER TO FILE YOUR CLAIMS. PLEASE GIVE CARD(S) TO RECEPTIONIST WHEN YOU RETURN THIS FORM. IF YOU ARE HERE DUE TO A MOTOR VEHICLE ACCIDENT OR A WORKER COMPENSATION CLAIM, PLEASE LET US KNOW.

POLICY HOLDER NAME: _____ **DATE OF BIRTH:** _____

POLICY HOLDER RELATION TO PATIENT: (CIRCLE ONE) SELF PARENT SPOUSE OTHER: _____

SOCIAL SECURITY NUMBER: _____ **NAME OF INSURANCE COMPANY:** _____

HOUSEHOLD INCOME / SLIDING FEE

Household Income

Number of people living in household _____ Total Annual/Yearly household income? (circle % category income falls into)

___Chose not to disclose

We offer a sliding fee discount program based only on your income and family size. If you would like to see if you qualify, please ask the receptionist for an application.

FAMILY SIZE	INCOME	CATEGORY 0	CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
%OF FEDERAL POVERTY INCOME GUIDELINES		100%	100.01% - 149.99%	150% - 174.99%	175% - 200%	>200%
Nominal Charge - MEDICAL		$10	$20	$30	$40	Pays 100% of Charges
1	Annual	$0 - $15,650	$15,651 - $23,473	$ 23,474 - $27,385	$27,386 - $31,300	$ 31,301 & up
2	Annual	$0 - $21,150	$21,151 - $31,722	$ 31,723 - $37,010	$37,011 - $42,300	$ 42,301 & up
3	Annual	$0 - $26,650	$26,651 - $39,972	$ 39,973 - $46,634	$46,635 - $53,300	$ 53,301 & up
4	Annual	$0 - $32,150	$32,151 - $48,221	$ 48,222 - $56,259	$56,260 - $64,300	$ 64,301 & up
5	Annual	$0 - $37,650	$37,651 - $56,471	$ 56,472 - $65,883	$65,884 - $75,300	$ 75,301 & up
6	Annual	$0 - $43,150	$43,151 - $64,720	$ 64,721 - $75,508	$75,509 - $86,300	$ 86,301 & up
7	Annual	$0 - $48,650	$48,651 - $72,970	$ 72,971 - $85,132	$85,133 - $97,300	$ 97,301 & up
8	Annual	$0 - $54,150	$54,151 - $81,219	$ 81,220 - $94,757	$94,758 - $108,300	$ 108,301 & up
*EACH ADDITIONAL FAMILY MEMBER		ADD $5,500 ANNUALLY				

X **PATIENT / GUARDIAN / RESPONSIBLE PARTY SIGNATURE** _____ **DATE:** _____

PATIENT REGISTRATION

It is always our priority to be welcoming to all patients and provide the highest quality of care possible. Monticello Medical Associates receives support from federal programs. These programs require that we collect the following demographic information. Some may be uncomfortable with the information we are collecting. If this is the case for you, please know that you always have the right to select choose not to disclose.

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:** _____
(FIRST) (MIDDLE) (LAST)

Race (check all that apply)
____ White
____ Black / African American
____ American Indian / Alaska Native
____ Asian Indian
____ Other Asian
____ Native Hawaiian
____ Other Pacific Islander
____ Filipino
____ Chinese
____ Japanese
____ Korean
____ Vietnamese
____ Samoan
____ Guamanian / Chamorro
____ Choose not to disclose

CHECK ALL THAT APPLY
____ Employed full time
____ Employed part time
____ Self Employed
____ Military Actively Enlisted
____ Student
____ Retired
____ Disabled
____ Unemployed
____ Seasonal Worker
____ Other: _____
____ Choose not to disclose

At any point in the last 2 years, has seasonal or migrant farm work been you or your family's main source of income?
___ Yes ___ No
___ Choose not to disclose

PREFERRED LANGUAGE:
____ English ____ Spanish
____ American Sign Language
____ French ____ Korean
____ Mandarin ____ Russian
____ Japanese ____ Cantonese
____ Hebrew ____ Arabic
____ Other: _____

Ethnicity
____ Hispanic / Latino
____ NOT Hispanic / NOT Latino
____ Mexican
____ Mexican American
____ Chicano
____ Puerto Rican
____ Cuban
____ Another Hispanic, Latino/a, or Spanish Origin
____ Choose not to disclose

ARE YOU HOMELESS?
____ Yes ____ No
___ Choose not to disclose
If yes, please select current living situation:
____ Permanent Supportive Housing
____ Doubling Up (multiple families living in same dwelling)
____ Shelter ____ Street
____ Transitional ____ Other

Sex Assigned at Birth
____ Male ____ Female
____ Choose not to disclose

Gender Identity
____ Male
____ Female
____ Transgender Man/Transgender Male/Transmasculine
____ Transgender Woman/ Transgender Female/Transfeminine
____ Other: _____
____ Choose not to disclose

Sexual Orientation
____ Heterosexual (or straight)
____ Lesbian or Gay
____ Bi-sexual
____ Other: _____
____ Don't know
____ Choose not to disclose

Which pronouns do you prefer?
___ He, Him, His
___ She, Her, Hers
___ They, Them, Theirs
___ Ze, Hir
___ Other: _____
___ Choose not to disclose

ARE YOU A VETERAN?
___ Yes ___ No
____ Choose not to disclose

X **PATIENT / GUARDIAN / RESPONSIBLE PARTY SIGNATURE** _____ **DATE:** _____