

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		FAMILY SIZE	INCOME MEASURE	CATEGORY 0	CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Number of people living in household _____ Total		% OF FEDERAL POVERTY INCOME GUIDELINES						
Annual/Yearly household income? (circle % category income falls into)		Nominal Charge - MEDICAL		\$10	\$20	\$30	\$40	Pays 100% of Charges
_____ Chose not to disclose		1	Annual	\$0 - \$ 15,960	\$ 15,961 - \$23,938	\$23,939 - \$27,928	\$27,929 - \$ 31,920	\$ 31,921 & up
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.		2	Annual	\$0 - \$ 21,640	\$ 21,641 - \$32,457	\$32,458 - \$37,867	\$37,868 - \$ 43,280	\$ 43,281 & up
		3	Annual	\$0 - \$ 27,320	\$ 27,321 - \$40,977	\$40,978 - \$47,807	\$47,808 - \$ 54,640	\$ 54,641 & up
		4	Annual	\$0 - \$ 33,000	\$ 33,001 - \$49,496	\$49,497 - \$57,746	\$57,747 - \$ 66,000	\$ 66,001 & up
		5	Annual	\$0 - \$ 38,680	\$ 38,681 - \$58,016	\$58,017 - \$67,686	\$67,687 - \$ 77,360	\$ 77,361 & up
		6	Annual	\$0 - \$ 44,360	\$ 44,361 - \$66,535	\$66,536 - \$77,625	\$77,626 - \$ 88,720	\$ 88,721 & up
		7	Annual	\$0 - \$ 50,040	\$ 50,041 - \$75,054	\$75,055 - \$87,564	\$87,565 - \$100,080	\$100,081 & up
		8	Annual	\$0 - \$ 55,720	\$ 55,721 - \$83,574	\$83,575 - \$97,504	\$97,505 - \$111,440	\$111,441 & up
		*EACH ADDITIONAL FAMILY MEMBER		ADD \$5,680 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

**PREFERRED LANGUAGE:**

English  Spanish  
 American Sign Language  
 French  Korean  
 Mandarin  Russian  
 Japanese  Cantonese  
 Hebrew  Arabic  
 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

**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

**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

**Sexual Orientation**

Heterosexual (or straight)  
 Lesbian or Gay  
 Bi-sexual  
 Other: \_\_\_\_\_  
 Don't know  
 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

**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

**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

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