

Marana Health Center Patient Registration

Patient Information

First Name \_\_\_\_\_ Mi \_\_\_\_\_ Last Name \_\_\_\_\_ Title \_\_\_\_\_
Address \_\_\_\_\_ Apt/Lot/Unit \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex: ( ) Male ( ) Female
Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Employer Name \_\_\_\_\_

Community Health Center Information

Race \_\_\_\_\_ Ethnicity: ( ) Hispanic ( ) Non-Hispanic ( ) Other Family Size \_\_\_\_\_
Annual Household Income ( ) \$1,000-\$10,000 ( ) \$10,000-\$25,000 ( ) \$25,000-\$50,000 ( ) \$50,000-\$75,000 ( ) \$75,000+
Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Responsible Party Information (if different than patient)

First Name \_\_\_\_\_ Mi \_\_\_\_\_ Last Name \_\_\_\_\_ Title \_\_\_\_\_
Address \_\_\_\_\_ Apt/Lot/Unit \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex: ( ) Male ( ) Female
Patients Relation To Responsible Party: ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_
Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Employer Name \_\_\_\_\_

Primary Insurance Information

Insurance Name \_\_\_\_\_
Address \_\_\_\_\_ Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Policy # \_\_\_\_\_ Group# \_\_\_\_\_ Copay \$ \_\_\_\_\_ Your Doctors Name \_\_\_\_\_
Subscriber First Name \_\_\_\_\_ Mi \_\_\_\_\_ Last Name \_\_\_\_\_ Title \_\_\_\_\_
Address \_\_\_\_\_ Apt/Lot/Unit \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex: ( ) Male ( ) Female
Patients Relation To Responsible Party: ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_
Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Employer Name \_\_\_\_\_

Secondary Insurance Information

Insurance Name \_\_\_\_\_
Address \_\_\_\_\_ Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Policy # \_\_\_\_\_ Group# \_\_\_\_\_ Copay \$ \_\_\_\_\_ Your Doctors Name \_\_\_\_\_
Subscriber First Name \_\_\_\_\_ Mi \_\_\_\_\_ Last Name \_\_\_\_\_ Title \_\_\_\_\_
Address \_\_\_\_\_ Apt/Lot/Unit \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex: ( ) Male ( ) Female
Patients Relation To Responsible Party: ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_
Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Employer Name \_\_\_\_\_

By signing this form I am consenting to Marana Health Center use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Marana Health Center Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Marana Health Center for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit

Patient/Person giving consent

Relationship if not patient

Date