MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

# CLIENT REGISTRATION FORM

Please complete this form so we can provide the best care possible. The information you share with us is part of your confidential medical record. Some infectious diseases must be reported to the Indiana State Department of Health in accordance with Indiana state law (IC 16-41-2-1).

PLACE LABEL HERE

## PLEASE PRINT

Birth Date: ________ / ________ / ________ Social Security Number: _______-_______-________
MM DD YYYY

Legal Name: ______________________________________________
First Middle Last

Other names used: ______________________________ Maiden: ______________________

Address: ______________________________________________
Street address City State Zip Code

Home phone: ( ______ ) ______________ Work phone: ( ______ ) ______________ Cell phone: ( ______ ) ______________

Email address: ______________________________________________

| Sex/Gender: | Marital Status | Primary Language: | Is the patient of a multiple birth? (twin, triplet, etc.) Check the box if the answer is Yes. ☐ |
|---|---|---|---|
| ☐ Male ☐ Trans (choose one) | ☐ Single ☐ Widowed | ☐ English | |
| ☐ Female ☐ male ⟶ female | ☐ Married ☐ Separated | ☐ Spanish | |
| ☐ female ⟶ male | ☐ Divorced | ☐ Other: _______ | |

**Please answer both questions: Please select all that apply.** *(This information is for statistical use only)*

**1. What is this person's race?**

- ☐ African American or Black
- ☐ American Indian or Alaskan Native - Specify tribe: __________
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Hawaiian Native
- ☐ Japanese
- ☐ Korean
- ☐ Other Asian: __________
- ☐ Other Pacific Islander: __________
- ☐ Other Race: __________
- ☐ Samoan
- ☐ Vietnamese
- ☐ White

**2. Is this client Hispanic/Latino?**

- ☐ No, not Spanish/ Hispanic/Latino
- ☐ Yes, Mexican, Mexican Am., Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/ Hispanic/Latino - Specify: __________

Country of birth: ______________________

Insurance Information
**Medicaid**
ID# ______________________
**Medicare**
ID # ______________________

Smoking Status (Select one if over the age of 12) ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Parent or guardian information (if under age 18)

Name: ______________________ Date of birth: ______ / ______ / ______ Relationship: ______________
MM DD YYYY

Address: ______________________ Phone Number: ( ______ ) ______________

In case of emergency, who should be contacted?

Name: ______________________ Phone Number: ( ______ ) ______________

**Acknowledgement of receipt of Notice of Privacy**

I have received a copy of this office's Notice of Privacy Practices. *(You may refuse to sign this acknowledgement)*

**Patient/Parent/Guardian signature:** ______________________ **Date:** ______________

**Authorization for Services**

I hereby authorize the Marion County Public Health Department to examine, test or provide services to the patient listed above. Test results and treatment will be explained to me as part of my visit today. If follow-up is needed or any test/exam results or appointment reminders, I will be contacted by a staff member.

**Patient/Parent/Guardian signature:** ______________________ **Date:** ______________

**HIPAA Refusal:** Please complete if client refuses to sign the acknowledgement section. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (please specify)

______________________ ______________
Authorized Employee Name (Print) Title (Print)

______________________ ______________
Employee Signature Date

# REGISTRATION FORM - PAGE 2

Birth Date: ____/_____ / _____
MM DD YYYY

Name: ____________________________________________
First Middle Last

School Name: ____________________

Grade: ____________________

**Please list everyone that lives with you**

| Name | Birthdate | Relationship | Gender | School | (Staff Use) MCPHD# |
|---|---|---|---|---|---|
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## PATIENT CONTACT AUTHORIZATION

The Marion County Public Health Department allows you to request to receive communications regarding appointments, lab results, treatment and/or other health information. ***Please check all that apply:***

☐ I do not want any contact made.

**Telephone Communication**

Home Phone ____________________

☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Cell Phone ____________________

☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Work Phone ____________________

☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Other ____________________

☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

☐ OK to leave a detailed message with: ____________________ ____________________
Name Relationship

**Written Communication**

☐ You may contact me by mail using my home address

☐ You may contact me by mail using my work/office address

☐ If you have any other special request, please list: ____________________

____________________ ____________________
Patient Signature Date

**If you change your mind after completing this authorization, you must submit a written cancellation of the authorization. This will not affect or undo any disclosure prior to this notification.**

### For Staff Use Only

| Date | Additional Addresses | Zip Code | Home Phone | Other Phone |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Other Hospital Patient Number: ____________________ Medicaid Caseworker: ____________________