MOLOKAI COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

TODAY'S DATE: _____

NAME: _____
Last Name First Name MI Preferred

GENDER: [ ] Male [ ] Female **DOB:** _____ **EMAIL:** _____

MAILING ADDRESS: _____
Street/PO Box City State Zip Country

PHYSICAL ADDRESS: _____
(if different) Street City State Zip Country

HOME PHONE: _____ [ ] Ok to Call **MOBILE PHONE:** _____ [ ] Ok to Call [ ] Ok to Text

I understand by providing my email address and opting to receive calls and/or texts, I am agreeing to receive autodialed, automated calls, texts and/or emails from MCHC. MCHC may send information to or contact me regarding my care, appointments and services provided or available to me. I also understand my consent is optional and standard text messaging and/or data rates may apply.

LANGUAGE: _____ **MARITAL STATUS:** [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Partner

RACE: [ ] American Indian/Alaskan Native [ ] Asian [ ] Black/African American [ ] Native Hawaiian [ ] Other Pacific Islander [ ] White
(Check all that Apply) [ ] Decline

ETHNICITY: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Unknown [ ] Decline

SEXUAL ORIENTATION: [ ] Lesbian or Gay [ ] Straight [ ] Bisexual [ ] Unknown [ ] Something else _____ [ ] Decline

GENDER IDENTITY: [ ] Male [ ] Female [ ] Transgender Male [ ] Transgender Female [ ] Non-Conforming [ ] Additional Gender [ ] Decline

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FAMILY SIZE: _____ [ ] Decline **INCOME:** $_____ [ ] Year [ ] Month [ ] 2 Weeks [ ] Week [ ] Decline

AGRICULTURAL WORKER: [ ] Yes [ ] No **HOMELESS:** [ ] Yes [ ] No **VETERAN:** [ ] Yes [ ] No **PUBLIC HOUSING:** [ ] Yes [ ] No

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EMERGENCY CONTACT: _____ **RELATION:** _____

HOME PHONE: _____ [ ] Ok to Call **MOBILE PHONE:** _____ [ ] Ok to Call [ ] Ok to Text

If patient is a minor, please provide the information below.

FATHER'S NAME: _____ **DOB:** _____

MOTHER'S NAME: _____ **DOB:** _____

GUARDIANS NAME: _____ **DOB:** _____

MEDICAL INSURANCE

PRIMARY INSURANCE: _____

INSURANCE ID #: _____

SUBSCRIBER: _____

SECONDARY INSURANCE: _____

INSURANCE ID #: _____

SUBSCRIBER: _____

DENTAL INSURANCE

PRIMARY INSURANCE: _____

INSURANCE ID #: _____

SUBSCRIBER: _____

SECONDARY INSURANCE: _____

INSURANCE ID #: _____

SUBSCRIBER: _____

MOLOKAI COMMUNITY HEALTH CENTER

CONSENT & ACKNOWLEDGEMENT

TODAY'S DATE: _____

NAME: _____ **DOB:** _____

CONSENT TO TREAT:
I hereby authorize Molokai Community Health Center to render any health services and treatment that is deemed necessary, to me in accordance with the policies and procedures of the Health Center. I understand that I retain the right to refuse any or all of the recommended health services and treatment.

CONSENT TO SHARE MEDICAL RECORDS:
I understand that my medical records could be shared within different departments of the Molokai Community Health Center and between HIPAA compliant entities through a health information exchange system. The information will be shared only to help in my health care assessment and management.

I understand that information regarding any and all prescription drugs I am currently taking and/or have taken in the past may be shared between my providers and the pharmacy. This authorization may include disclosure of prescription details related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information.

I also understand that at any time during the course of receiving health services and treatment, a referral to a specialist is required, details from my medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

I hereby authorize Molokai Community Health Center to release my medical record to be reviewed for the purposes of an auditor and/or evaluation. The purpose of this review is to enhance patient care and to comply with managed care requirements. I understand that no identification of my name, date of birth or address will be recorded during this review process.

I understand that I can receive a copy of my medical records for personal use for a fee of $.50 per page if the medical record is over 10 pages.

CONFIDENTIALITY:
I understand that Molokai Community Health Center has a strict policy regarding privacy and confidentiality of my medical information. The Notice of General Patient Rights & Privacy Practices of the Health Center includes additional information about the use and disclosures of medical information. A copy is displayed in the waiting room and can be provided to you upon request.

MEDICAL INSURANCE AUTHORIZATION & ASSIGNMENT:
I hereby authorize Molokai Community Health Center to furnish information concerning my health services and treatment to my insurance carrier. I hereby also assign to Molokai Community Health Center, all the payments for my health services and treatment rendered. I understand that I am responsible for any amount not covered by my insurance.

ACKNOWLEDGEMENT:
I understand that this consent in its entirety will remain in effect as long as I continue to receive health services and treatment at Molokai Community Health Center. You have the right to revoke this consent provided that you do so in writing, except to the extent that we have already used or disclosed the information in reliance on the consent.

_____ _____

SIGNATURE OF PATIENT **DATE**

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN **(Must present proof of guardianship)** **DATE**

MOLOKAI COMMUNITY HEALTH CENTER

REQUEST OF HEALTH INFORMATION

TODAY'S DATE: _____

NAME: _____ **DOB:** _____

ADDRESS: _____

AUTHORIZATION: I authorize the provider listed below to disclose my health information with Molokai Community Health Center.

[ ] Fax Records:
Medical: (808)553-5194
Dental: (808)553-3591
BH: (808)553-5854

[ ] Mail Records:
PO Box 2040
Kaunakakai HI 96748

PROVIDER: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

INFORMATION REQUESTED:

[ ] Complete Records
[ ] Emergency Room Records
[ ] Imaging/Lab Reports
[ ] Other: _____

PURPOSE OF REQUEST:

[ ] Change of Physician
[ ] Other: _____

ACKNOWLEDGEMENT:
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

I understand I may revoke this authorization at any time by notifying the Molokai Community Health Center in writing. I understand that the revocation will not apply to any information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one year from my date of signature below.

I understand the authorization is voluntary. I can refuse to sign this authorization and Molokai Community Health Center will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: research-related treatment, health care provided solely for disclosure to a third party or health plan initial enrollment/eligibility determinations, underwriting or risk rating determination.

I hereby release Molokai Community Health Center from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Molokai Community Health Center.

I have read the above and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
SIGNATURE OF PATIENT **DATE**

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN **(Must present proof of guardianship)** **DATE**