



Registration Form

Welcome to MetroHealth. We are pleased that you have chosen us as your medical home. Please complete the following information and let us know if you need any help or assistance. PLEASE PRINT CLEARLY.

CLIENT INFORMATION					
Today's Date:	Date of Birth:	Country Of Birth:	Social Security Number:		
First Name:		Last Name:		Middle Name:	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Female to Male)				
Address:	Street:	Unit:	Ward:		
	City:	State:	Zip:		
Can MetroHealth send you mail to this address?	<input type="checkbox"/> Yes If no, please provide an address where MetroHealth can send mail or visit (if necessary): <input type="checkbox"/> No				
	Please describe your current housing situation: <input type="checkbox"/> Stable <input type="checkbox"/> Somewhat Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Homeless				
Your Contact Information:	Please provide contact information at which we can identify ourselves as MetroHealth. Please notify us of any changes to your contact information.				
	Phone #1: () <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Friend / Family				
	Phone #2: () <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Friend / Family				
Email address:					
Emergency Contact Information:	Name:		Relationship:		
	Address:		Phone Number:		

ADDITIONAL CLIENT INFORMATION			
<u>Marital Status:</u> <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	<u>Ethnicity:</u> <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non- Hispanic / Latino <input type="checkbox"/> Unknown	<u>Preferred Languages:</u> <input type="checkbox"/> Amharic <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	<u>How did you hear about MetroHealth?</u> <input type="checkbox"/> Ad / flyer / website <input type="checkbox"/> Insurance company <input type="checkbox"/> Referred by medical provider <input type="checkbox"/> Friend <input type="checkbox"/> MetroHealth testing program <input type="checkbox"/> Another agency's testing program <input type="checkbox"/> Community event <input type="checkbox"/> Support group <input type="checkbox"/> Other:
<u>Employment:</u> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Student <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	<u>Race:</u> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More Than One Race Other:	<u>Do you have any special needs?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:	<u>Advance Directives:</u> If you have an advance medical directive (living will, power of attorney, etc.) please bring in a copy at your next visit



PAYMENT FOR SERVICES

Insurance Information:	Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<i>If yes, please complete the following information. If no, please skip to the income section below.</i>		
	Insurance Group Name:	Insurance Number:	
	Insured's Name:	Relationship to Client:	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other:
	If you are a DC resident without insurance, are you interested in applying? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Income Information:	# of Household Members:	Annual Salary:	<input type="checkbox"/> \$0-11,490 <input type="checkbox"/> \$11,491-22,980 <input type="checkbox"/> \$22,981-34,470 <input type="checkbox"/> \$34,471-45,960 <input type="checkbox"/> \$45,961-57,450 <input type="checkbox"/> > \$57,451
	<p>Time of Service Payment: It is the policy of MetroHealth to collect payment at the time of service. This includes all co-pay amounts, deductibles, private individuals, and sliding fee co-pay. This does not include fees covered by insurance plans in which MetroHealth participates.</p> <p>By providing my signature below, I certify that the information I have given on my income and insurance is correct. I authorize MetroHealth to apply for benefits on my behalf. I request that payment from my insurance company be made directly to MetroHealth. I authorize the release of any information, including medical information, to my insurance company. This may be necessary to determine and pay insurance benefits to which I am entitled. Either my insurance company or I may revoke this authorization at any time by providing written notice.</p>		
Signature of Client:		Date:	