MetroHealth
Multidisciplinary and Integrated Healthcare

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:	□ Male □ Female	□ Transgender (Male to Female) □ Transgender (Female to Male)					
Address:	Street:		Unit:		Ward:		
	City:		State:		Zip:		
Can MetroHealth send you mail to this address?	□ Yes □ No	If no, please provide an address where MetroHealth can send mail or visit (if necessary):					
	Please describe your current housing situation:	□ Stable □ Unstable	□ Somewhat Stable □ 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: ( )	□ Cell Phone	□ Home	□ Work	□ Friend / Family		
	Phone #2: ( )	□ Cell Phone	□ Home	□ Work	□ Friend / Family		
	Email address:						
Emergency Contact Information:	Name:		Relationship:				
	Address:		Phone Number:				

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

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<table>
<tr><th colspan="5">PAYMENT FOR SERVICES</th></tr>
<tr><td rowspan="4">Insurance Information:</td><td colspan="4">Do you have health insurance? □ Yes □ No</td></tr>
<tr><td colspan="4">If yes, please complete the following information. If no, please skip to the income section below.</td></tr>
<tr><td colspan="2">Insurance Group Name:</td><td colspan="2">Insurance Number:</td></tr>
<tr><td colspan="2">Insured's Name:</td><td colspan="2">Relationship to Client: □ Self □ Parent □ Spouse □ Other: _____</td></tr>
<tr><td colspan="5">If you are a DC resident without insurance, are you interested in applying? □ Yes □ No</td></tr>
<tr><td>Income Information:</td><td># of Household Members:</td><td>Annual Salary:</td><td colspan="2">□ $0-11,490 □ $11,491-22,980 □ $22,981-34,470
□ $34,471-45,960 □ $45,961-57,450 □ > $57,451</td></tr>
<tr><td colspan="5"><u>Time of Service Payment:</u> 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.</td></tr>
<tr><td colspan="5">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.</td></tr>
<tr><td colspan="3">Signature of Client:</td><td colspan="2">Date:</td></tr>
</table>