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:
☐ Male ☐ Female ☐ Trans (choose one) ☐ male → female ☐ female → male

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Language:
☐ English ☐ Spanish ☐ Other: _____

Is the patient of a multiple birth? (twin, triplet, etc.) Check the box if the answer is Yes. ☐

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#

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: _____