Registration

Patient ID Number _____

Patient Information

Last Name:	First Name:	MI:
Address:		Apt #
City/State/Zip:		
Home Phone:	Cell:	Work:
Preferred Method of Contact for reminder calls and other electronic generated messages: ____ Voice ____ Text ____ Email Address_____		If Voice, select preferred number: _____ Home _____ Cell _____ Work
Date of Birth:	Social Security:	
Gender Preference: ___ Male ___Female ___Transgender Male from Female ___Transgender Female from Male ___ Gender Queer ___Other		
Preferred Gender Pronoun: ___ He/Him ___She/Her ___Something Else_____	**Sexual Orientation**: (check all that apply) ____Straight or Heterosexual ____Bisexual ___Lesbian, Gay or Homosexual ___ Something Else/Other ___Questioning/ Unknown __ Not Disclosed	

Maritial Status:	Employment Status:	Retired	Unemployed	Employed Full Time Employed Part Time
Employer Name:		Emergency Contact Name:		
Emergency Contact Phone:		Relationship to Patient:		

Responsible Party / Guarantor

Last Name:	First Name:	MI:
Date of Birth:	Social Security#	Phone:
Address of Responsible Party:		
City/State/Zip:		
Gender:	Relationship to Patient:	Email:

Employment Status:	Retired	Unemployed	Employed Full Time	Employed Part Time

Additional Information (please fill out all sections below)

Email Address:		**Can we leave a message regarding your medical care and test results?** YES NO	
Race: (please select) ___Asian ___American Indian /Native American ___Alaskan Native	___Black/African American ___Native Hawaiian ___Pacific Islander	___White/Caucasian ___More than one race ___Unreported/Refused	Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino ___Unreported/Decline

Migrant Farm Worker:	YES NO	Live in Public Housing:	YES NO	Homeless:	YES NO	Veteran:	Veteran Non Veteran
What language(s) do you speak at home?							

Income Per Month:	Annual:					Family Size:	
Pharmacy							
Pharmacy Name and Location:							
Primary Medical Insurance						**Primary Dental Insurance**	
Ins. Co. Name						Ins. Co. Name:	
Policy Holder Name:						Policy Holder Name:	
How Did You Hear About Us?	HealthFair	Community Event	School	Friend	Social Media	Other	

Notice of Financial Policy, Insurance Authorization Agreement:

Mission East Dallas will charge persons receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at a

reduced charge to qualified persons unable to pay full price for services . In addition will be charged for services to the extent that payment wil be made

by a third party authorized or under legal obligationto pay charges. Mission East Dallas will not discriminate against any persons receiving health services

because of their inability to pay or because payment will be made under the Medicare or Medicaid programs, we have agreements in place to accept assignment.

I accept financial responsibility for all treatment provided by Mission East Dallas. I authorize release of any information to my insurance companies

I authorize my insurance benefits including Medicare be paid directly to Mission East Dallas and acknowledge I am finacially responsible for any balances.

Signature: **Print Name:** **Date:**