Mary Mahoney Memorial Health Center
Client Registration Information

Date: _____

Responsible Party Information: PLEASE PRINT

Name: _____ Acct#: _____

Address: _____ SSN#: _____

City: _____ State: _____ Zip: _____ D.O.B. _____

Phone Home: _____ Sex: _____

Work: _____ Marital Status _____

Income (Include Spouses): _____ Weekly Monthly Bi-Monthly Yearly Family Size: _____

Salary: Social Security Medicaid Unemployment Other _____

Currently without income, receiving financial assistance from: Name: _____ Phone: _____

Patient Information:

Name: _____ D.O.B: _____

Address: _____ SSN#: _____

City: _____ State: _____ Zip: _____ Sex: _____ Race: _____

Emergency Contact: Name: _____ Phone: _____

Family Information: SPOUSE AND MINOR CHILDREN ONLY

Name Last, First, Middle	Sex	D.O.B.	Social Security Number	Chart #	Race
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Insurance Information:

1. Name of Insurance: _____
   Policy #: _____
   Group #: _____
   PCP: _____

2. Name of Insurance: _____
   Policy #: _____
   Group #: _____
   PCP: _____

Please have your driver's license, Social Security card, and insurance cards available to make a copy for your chart. Please Read and Sign Back.

MARY
MAHONEY
MEMORIAL HEALTH CENTER

P.O. Box 30589 • 12716 N.E. 36th Street • Oklahoma City, Oklahoma 73146 • Telephone (405) 769-3301 • Fax : (405) 769-9685

CONSENT FOR TREATMENT/SERVICES

I hereby apply for care under this program based on the information given and permit the personnel of Mary Mahoney Memorial Health Center to verify any of the information I have furnished.

I understand that demographic (Age, Sex, Race, Income, etc.) information about me and/or my family and information about the number of services that I/we receive may be used without my name. This information will assist the Health Center in its efforts to obtain services that will help me/my family and for future planning of services in Oklahoma City.

I hereby authorized the staff and personnel of Mary Mahoney Memorial Health Center to perform such diagnosis procedures and other medical/dental procedures as they may deem necessary or advisable from time to time.

I further authorize Mary Mahoney Memorial Health Center to release any appropriate medical information to any hospital to which I/my family may need to be admitted, or to a professional consultant, selected physicians of Mary Mahoney Memorial Health Center.

I further understand that if I have failed to give correct and complete information regarding the questions I have been asked, I/my family as listed is subject to 100% payment billing and subsequently standard collection procedures for delinquent accounts regardless of my payment source.

I understand I am responsible for the payment for all services received at the Health Center that are not paid by any other source.

_____ _____
(Signature of Head/Spouse/Guardian) (Date)

_____ _____
Witness (Date)

ADVANCE DIRECTIVE (21 Y.O. +)

Do you have an "Advance Directive" (Written direction about your health care decisions—Living Will)?

_____ Yes _____ No

If yes, Would you please furnish MMMHC a copy of your "Advance Directive?" Yes / No