MoZaic Care

PATIENT REGISTRATION FORM

Date: ……..

What name I wish to be called: ……

For completion purposes, if you have insurance, what gender do they have on file for you?
☐ Female ☐ Male

Name as it appears on your insurance card: ……

Address: …… Apt/Unit: ……

City: …… State: …… Zip: …… Date of Birth: …… / …… /……

Home phone number: …… Cell phone number: ……

Email: …… SS#: ……

Occupation: …… Work Phone: ……

OK to leave a confidential voicemail? ☐ Yes ☐ No If yes, what number: ☐ Home ☐ Cell ☐ Work

Would you like to receive text messages from our office? ☐ Yes ☐ No

Would you like to sign-up for our patient portal? ☐ Yes ☐ No

Emergency Contact: …… Relation: …… Phone number: ……

Preferred Language: ☐ English ☐ Spanish ☐ …… Interpreter required? ☐ Yes ☐ No

Ethnicity: ☐ Decline to State ☐ Hispanic or Latino/Spanish ☐ Not Hispanic/Latino
Race: ☐ Decline to State ☐ American Indian or Alaskan Native ☐ Asian ☐ White
☐ Black or African American ☐ Other

Primary Care Physician: …… Phone number: ……

Preferred Pharmacy: …… Address: …… Phone number: ……

Preferred Lab: …… Location: …… Phone: ……

Referral Source: ☐ Self ☐ Friend or Family ☐ Doctor -name: …… ☐ Other: ……

Primary Insurance Information: (We require a copy of your insurance cards and photo ID)

Carrier: …… ID#: …… Group#: ……

Subscriber's Name: ☐ Self ☐ Other …… Relationship: ……

Secondary Insurance Information:

Carrier: …… ID#: …… Group#: ……

Subscriber's Name: ☐ Self ☐ …… Relationship: ……

CHECK ALL THAT APPLY:

My gender identity is:

- ☐ Woman
- ☐ Man
- ☐ Transgender woman
- ☐ Transgender man
- ☐ Gender non-conforming
- ☐ Genderqueer
- ☐ ……
- ☐ Decline

My sex assigned at birth is:

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ ……
- ☐ Decline

My sexual orientation:

- ☐ Lesbian
- ☐ Gay
- ☐ Queer
- ☐ Bisexual
- ☐ Heterosexual
- ☐ Asexual
- ☐ Pansexual
- ☐ Questioning
- ☐ Decline
- ☐ ……

My pronouns are:

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/Them/Theirs
- ☐ Ze/Hir/Hirs
- ☐ ……

My marital status is:

- ☐ Single
- ☐ Married
- ☐ Partnered
- ☐ Divorced
- ☐ Separated
- ☐ Widow
- ☐ Decline

My living situation is:

- ☐ Rent
- ☐ Own
- ☐ Live with friend / family
- ☐ ……

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand this is not a guarantee of payment and that I am financially responsible for any balance due.
I also authorize **MoZaic Care** or my insurance company to release information required to process my claims.

Patient Legal Name: ……

Patient Signature: …… **Date:** ……

Parent or Guardian Signature: …… Date: ……

A parent or guardian must sign if the patient is under 18 years of age, except if the patient is an emancipated minor.