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: …… Preferred Phone Number: ……

Date of Birth: …… / …… /…… SS#: ……

Email: ……

OK to leave a confidential message on the above preferred number? □ Yes □ No

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

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

Occupation: …… Work Phone: ……

Emergency Contact: …… Relationship: …… Phone: ……

Preferred Language: □ English □ Spanish □ Other ……

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: ……

Preferred Pharmacy: …… Location: …… Phone: ……

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

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

Primary Insurance Information: (We will 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
- ☐ Trans Female-to-Male (FTM)
- ☐ Trans Male-to-Female (MTF)
- ☐ Gender non-conforming
- ☐ Genderqueer
- ☐ Other: ……
- ☐ Decline

My sex assigned at birth is:

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Other: ……
- ☐ Decline

My sexual orientation:

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

My pronoun is:

- ☐ She/her
- ☐ He/his
- ☐ They/Them/Their
- ☐ Zie/Hir
- ☐ Other: ……

My marital status is:

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

My living situation is:

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

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.