MoZaic Care

PATIENT REGISTRATION FORM

Date: ……

Preferred Name: ……

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: ……

Home Phone: …… Cell Phone: ……

OK to leave a confidential message on above numbers? ☐ Yes ☐ No

Email: ……

Date of Birth: …… SS#: ……

Employer/Occupation: …… Work Phone: ……

Emergency Contact: …… Relationship: ……

Home Phone: …… Cell Phone: ……

Preferred Language: ☐ English ☐ Spanish ☐ Other ……

Ethnicity: ☐ Decline to State ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race: ☐ Decline to State ☐ American Indian or Alaskan Native ☐ Asian ☐ White
☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other

Primary Care Physician: …… Phone: ……

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

Primary Insurance Information: (Please give all card's to the receptionist)

Carrier: …… ID#: …… Group#: ……

Subscriber's Name: ☐ Self ☐ …… 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)
- ☐ 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 preference 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. I also authorize **MoZaic Care** or my insurance company to release information required to process my claims.

Patient Name: ……..

Patient Signature: …… Date: ……

Parent or Guardian Signature: …….. Date: ……

A parent or guardian must sign if the patient is under 18 years of age but not if the patient is an emancipated minor.