Metro Community Provider Network

Patient Number_____
(For Office Use Only)

WELLNESS CENTER ENROLLMENT FORM

All information is strictly confidential!

Please Print

A. PATIENT INFORMATION:

Last Name:_____ Male/Female:_____ Race:_____

First Name &
Middle Initial:_____ Primary Language:_____

Home Address:_____ SSN_____

City:_____ State:_____ Zip:_____ School:_____

Birth Date:_____ Grade:_____ Teacher:_____

Home Phone:_____ Work Phone:_____

B. OTHER FAMILY MEMBERS IN HOUSEHOLD

Father:_____ Birth Date:_____

Mother:_____ Birth Date:_____

Brother/Sister:_____ Birth Date:_____

Brother/Sister:_____ Birth Date:_____

Who does the child live with?_____ Relationship:_____

C. CHILDS MEDICAL HISTORY

What is the child's usual source of medical care? ☐ None ☐ Emergency Room ☐ Doctor/Clinic

Doctors Name:_____ Doctors Phone:_____

Doctors Address:_____

When was your child's last check-up?_____ Does your child regularly see a dentist?_____

Dentist's Name:_____ Dentist's Phone:_____

D. HEALTH CARE INSURANCE

☐ Private Insurance Name of Plan:_____ Patient Number:_____

☐ Medicaid HMO:_____ PCP_____ Number:_____

☐ CICP/CRDP Rating:_____ ☐ CCHP+ ☐ No Insurance ☐ Other_____

E. IN CASE OF AN EMERGENCY

Please give us the name of one person we can call if we can not reach the child's parent.

Name:_____ Phone:_____

Relationship to you:_____

F. INSURANCE PAYMENT AUTHORIZATION & RELEASE

I hereby authorize my insurance benefits to be paid directly to the above MCPN clinic, and acknowledge that I am financially responsible for unpaid balance. I also authorize MCPN to release any information to the insurance company.

_____ _____
Parent Signature Date