UMMA COMMUNITY CLINIC
Healthcare for all, inspired by Islam

PATIENT INFORMATION

Last Name:_______________________ **First Name:**_______________________ **MI:** ______

Social Security Number:_______________________ **Date of Birth:** _______________________

Address:_______________________ **City:**_______________ **Zip Code:** ______________

Telephone:_______________________ **Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widow ❑ Partner

Email Address:_______________________ **Other names you have used:** _______________

MediCal/Insurance ID Number:_______________________ **Issue Date:** _______________

Sex: ❑ Female ❑ Male
Gender Identity: ❑ Male ❑ Female ❑ Transgender Male/Female to male ❑ Transgender Female/Male to female
❑ Choose not to disclose ❑ Other
Sexual Orientation: ❑ Lesbian or Gay ❑ Straight (not lesbian or gay) ❑ Bisexual
❑ Something else ❑ Don't know ❑ Choose not to disclose

Are interpreter Services Needed? ❑ Yes ❑ No **Primary Language:** ❑ English ❑ Spanish ❑ Other: _______________

Where do you currently live? ❑ At a shelter ❑ Staying with others ❑ The street, a camp, under a bridge, or in a car
❑ In transitional ❑ In my home

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refused/Prefer Not to Disclose **Veteran Status:** ❑ Yes ❑ No

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White
❑ Unreported/Refused to Report ❑ Black or African American

Do you have an Advanced Directive? ❑ Yes ❑ No **Mother's Maiden Name:** _______________________

Employer Name:_______________________ **Phone #:** _______________________

Emergency Contact Information *(for patient, or for responsible party if patient is a minor):*

Emergency Contact Name:_______________________ **Phone # :** _______________

Relationship to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Grandparent ❑ Other: _______________

Other Contact: ❑ Message ❑ Cell Phone ❑ Email ❑ Confidential _______________________

Guarantor Information *(The person responsible for payment, example: a parent for a patient under 18 years of age)*

Last Name:_______________________ **First Name:**_______________________ **MI:**________

Billing Address: ❑ same as above_______________________ City/Zip: _______________

Relationship to patient: ❑ Parent ❑ Spouse ❑ Other _______________

Income Information: *Information provided is used to offer discounts to you.*

Family Income: $_________________________per ❑ Year ❑ Month ❑ Week # of persons in Family ____________________

Authorization for and Consent to Medical Services

1. I do hereby fully and freely give my consent and approval to the University Muslim Medical Association Inc. Community Clinic (hereafter, "UMMA"), a non-profit, charitable institution, and to its physician or physicians, to make any medical examinations, x-rays, laboratory tests, medical and minor surgery, as may be necessary, in the judgment of the physician or physicians, for the betterment of

NAME OF PATIENT: ____

2. I hereby agree that protected health information obtained in the course of such treatments may be provided by UMMA to any hospital, clinic, agency, business associate for treatment, or payer. For a more detailed description of uses and disclosures for these purposes, please request a copy of our Notice of Information Practices ("Notice"). I have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, I may obtain a revised Notice by simply contacting UMMA at (323) 789-5610. I have the right to request that we restrict our uses or disclosures of my protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. Finally, I have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it. I also understand that by refusing to sign this consent or revoking this consent, UMMA may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations

3. I hereby give permission to UMMA's medical personnel to requisition any pertinent data from medical records of treatment provided to the above-named person by any hospital, clinical, or doctor who may have treated him/her prior to this date.

4. I agree that if I discontinue medical care for myself or my child at UMMA, contrary to the opinions and decisions of UMMA's physician(s), I will thereby relieve UMMA of all responsibility for the health of myself or my child

The undersigned certifies that he/she has read the foregoing, and in the case that the patient is a minor, the undersigned certifies that he or she is the parent or guardian of the patient.

The undersigned authorizes any of the following adults listed here to bring this child in for medical services, special diagnostic or therapeutic procedures on her/his behalf.

Name of Adult	Age	Relationship to Child
1.		
2.		
3.		
4.		

Patient Signature:____ **Date:** ______________

Parent/Guardian Signature:______________________________________ **Date:** ______________

FOR UMMA STAFF ONLY

*Entered by:*________________________________*Date:*__________________*ACCT #:* _