

PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Last Name (Legal)		First Name	M.I.	Date of Birth	Sex M F
Mailing Address		City		State	Zip Code
Home Phone #	Cell Phone #	Social Security #	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
			Student Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not a student		
Employer Name:		Employer Address:		Employer Phone #	
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> None					
Emergency Contact Name: (Not living in same household)			Relationship:	Emergency Contact Phone #:	
Email Address:					
Ethnicity: Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No			Preferred Language:		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander					
<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> More than one race <input type="checkbox"/> Other <input type="checkbox"/> Refused					
Are you a Military Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you an Agricultural Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Living Arrangements: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Living w/ relatives <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Doubling Up <input type="checkbox"/> Other					
REFERRAL SOURCE (How did you hear about us?)					
<input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Phone Book <input type="checkbox"/> Patient <input type="checkbox"/> Other - Advertising <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other Agency <input type="checkbox"/> Newspaper <input type="checkbox"/> None					
PHARMACY PREFERENCE					
Pharmacy Name:			City:	State:	
HEAD OF HOUSEHOLD INFORMATION (Person Responsible for Account if different than above)					
Last Name (Legal)		First Name	M.I.	Date of Birth	Sex M F
Mailing Address		City		State	Zip Code
Home Phone #	Cell Phone #	Social Security #	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
			Student Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not a student		
Employer Name:		Employer Address:		Employer Phone #	
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> None					
INCOME INFORMATION					
Would you like to Apply for the Sliding Fee Discount? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes" we will need Proof of HOUSEHOLD Income)					
Family Size:		Annual Gross Family Income: \$		(Estimate)	<input type="checkbox"/> Refuse <input type="checkbox"/> None
INSURANCE (need copy of card):					
Primary Insurance: _____			Effective Date: _____		
Policy Id: _____		Group #: _____		Group Name: _____	
Policy Holder Name: _____			Policy Holder DOB: _____		
Policy Holder SSN: _____					
Policy Holder Address: _____					
Policy Holder Phone #: _____					
If secondary insurance please use "Internal Financial Face Sheet - Insurance Verification" Form (Done by a CHCCW Employee)					

AUTHORIZATION AND ASSIGNMENT

The information provided on this form is true and correct to the best of my knowledge.

Treatment/Payment Agreement for the Community Health Center of Central Wyoming (CHCCW)

I request the above to provide me and/or my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to CHCCW. Also, I authorize CHCCW to bill my insurance by electronic filing through a billing agency and to release any medical information needed for processing claims. In the event an X-ray and/or Lab test(s) are performed during my visit, I authorize CHCCW to release patient information to the external agency for the purpose related to the processing and billing of the ordered film(s) and/or test(s).

Signature: _____

Date: _____

ALL SPACES MUST BE COMPLETED