COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
CASPER • DUBOIS • RIVERTON

Pt ID # _____

PATIENT REGISTRATION FORM

5000 Blackmore Road Casper, Wyoming 82609

Last Name	**First Name**	**Middle Initial**	**Preferred Name**
Date of birth	**Sex at Birth** □ Male □ Female □ Decline	**Mailing Address**	**City** **State** **Zip**
Home Phone	**Cell Phone**	**What is your marital status?** □ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed	
Social Security Number	**Email Address**	**Preferred Pharmacy**	

RESPONSIBLE PARTY INFORMATION

First/Last Name	**Employer**		**Social Security #**
Street address	**City**	**State**	**Zip**
Date of birth	**Gender** □ Male □ Female	**Phone Number**	**Patients Relation to Guarantor**

INSURANCE

Insurance company	**Employer**	
Policy holder's first and last name	**Policy holder's date of birth**	**Policy holder's social security #**

HEALTH CENTER FUNDING INFORMATION

In order to continue the variety of services that we offer here at CHCCW and to continue to receive grant funding, we are required to collect the following information on every person that visits our facility. This information is reported as a cumulative number and not reported on individual patients.

What is your household annual income?
□ <$10,000
□ $10,000-14,999
□ $15,000-19,999
□ $20,000-29,999
□ $30,000-49,999
□ $50,000-79,999
□ $80,000 -99,999
□ $100,000 +

How many people in your family? (yourself, spouse and minor children under 18 years) _____

Veteran Status:
□ Veteran
□ Not a veteran

Homeless Status:
□ Shelter □ Street
□ Transitional Housing
□ No

Agricultural Status over the last 3 years:
□ Migrant □ Seasonal □ No

Student Status:
□ Student full time
□ Student part time

Employment Status:
□ Employed full time
□ Employed part time
□ Unemployed
□ Retired
□ Disabled

Employer Name:
_____

Employer Address:
_____

Racial Group(s):
□ African American/Black
□ Asian
□ Caucasian/White
□ Multiracial
□ Native American/Alaskan Native
□ Pacific Islander
□ Other:

Referral Source:
□ Billboard
□ Radio
□ Business/Agency
□ Friend or Family
□ Fair/Festival/Event
□ Hospital/Clinic
□ Internet Search
□ Social Media
□ Newspaper

What is your gender identity? **Only if over 12 years of age
□ Male
□ Female
□ Transgender Male/Trans Man/FTM
□ Transgender Female/Trans Woman/MTF
□ Gender Queer
□ Chose not to disclose

Preferred Language:
_____

Do you need an Interpreter?
□ Yes □ No

Ethnicity:
□ Hispanic/Latino/Latina
□ Non-Hispanic/Latino/Latina

Do you think of yourself as: **Only if over 12 years of age
□ Lesbian, gay, or homosexual
□ Straight or heterosexual
□ Bisexual
□ Something else
□ Don't know
□ Chose not to disclose

What pronouns do you use? **Only if over 12 years of age
□ he/him
□ she/her
□ they/them

EMERGENCY CONTACT INFORMATION

Emergency contact	**Relationship to patient**	**Phone number**

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CONSENT TO TREATMENT:

I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning, birth control methods, and immunizations as deemed advisable by the professional staff of Community Health Centers of Central Wyoming (CHCCW). I am aware that a Physician or a Nurse Practitioner may provide the medical care. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at any of the Community Health Centers of Central Wyoming clinic sites. I may cancel this consent in writing.

I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the hospital assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or pre-recorded messages in contacting me.

Signed: **X**_____ _____

Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (print) Relationship

AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:

I authorize CHCCW to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also CHCCW may use and release any part of my medical records necessary to the process of billing third party payers for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Community Health Centers of Central Wyoming for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any Community Health Centers of Central Wyoming account may be applied to my patient balance. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: **X**_____ _____

Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (print) Relationship

PROTECTED HEALTH INFORMATION DESIGNEE:

I understand that the individuals identified below will be treated by Community Health Centers of Central Wyoming as individuals involved directly in my care or my child's care, and as such CHCCW will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making appointments, bringing a minor child for medical treatment, and all other functions normally associated with individual patient care, payment, and health care operations.

Name of Designee: _____ Relationship to Patient: _____

Name of Designee: _____ Relationship of Patient: _____

☐ *I decline to provide a protected health information designee contact for myself or my child at this time.*

Patient Signature/Parent/Legal Guardian_____ Date: _____

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AS A PATIENT, I AGREE TO THE FOLLOWING:

- I agree to treat staff and clients of CHCCW with dignity and respect.
- I will arrive to my appointment on time.
- I will cancel appointments at least 2 hours before or it will be considered a "No Show". Repeat "No shows" could result in you losing privileges to schedule future appointments.
- I have been given the opportunity to ask any questions I have about my care through CHCCW.
- I can request a copy of all authorization documents such as Notice of Privacy Practices (HIPAA), Patient responsibilities, and CHCCW Responsibilities and Duties.
- I understand and am aware children may not be left in the waiting area while I am being treated and I must reschedule my appointment if I do not have appropriate supervision/care for the children.

Signed: **X**_____ _____
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____
Full name (print) Relationship

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