COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING

PATIENT REGISTRATION FORM

We are your health

5000 Blackmore Road Casper, Wyoming 82609

Last Name	First Name	Middle Initial	Preferred Name

Date of birth	Sex at Birth □ Male □ Female	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	Are you interested in accessing the patient portal? □Yes □No

Do you have an Advance Directive? □ Yes □ No
Do you have a Living Will? □ Yes □ No
Do you have a Power of Attorney? □ Yes □ No

Employment Status: □ Full Time □ Part Time □ Unemployed □ Retired □ Disabled
Employer Name:_____
Address:_____

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

PRIMARY MEDICAL INSURANCE

Insurance Company	Policy/Member ID #	

Policy Holder Name	Policy Holder Date of Birth	Policy Holder Social Security #

PRIMARY DENTAL INSURANCE

Insurance Company	Policy/Member ID #	Group #

Policy Holder Name	Policy Holder Date of Birth	Policy Holder 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 □ $30,000-49,999
□ $10,000-14,999 □ $50,000-79,999
□ $15,000-19,999 □ $80,000 -99,999
□ $20,000-29,999 □ $100,000 +

How many people live in your home? (include only tax dependents)
_____

Are you in need of financial assistance? □ Yes □No

Veteran Status:
□ Veteran □ Not a veteran
□ Chose not to disclose

Homeless Status:
□ Homeless □ Not Homeless
□ Chose not to disclose

Agricultural Status over the last 3 years:
□ Migrant □ Seasonal □ Not
□ Chose not to disclose

Student Status:
□ Not a student
□ Full time □ Part time
□ Chose not to disclose

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

Ethnicity:
□ Hispanic/Latino/Latina
□ Non-Hispanic/Latino/Latina
□ Chose not to disclose

Racial Group(s):
□ African American/Black
□ Asian
□ Caucasian/White
□ Native American/Alaskan Native
□ Pacific Islander
□ Native Hawaiian
□ More than one
□ Other
□ Chose not to disclose

Do you think of yourself as:
**Only if over 18 years of age
□ Lesbian or gay
□ Straight (not lesbian or gay)
□ Bisexual
□ Something else
□ Don't know
□ Chose not to disclose

What is your gender identity?
**Only if over 18 years of age
□ Male
□ Female
□ Transgender Male/FTM
□ Transgender Female/MTF
□ Other
□ Chose not to disclose

Preferred Language:
_____

Do you need an Interpreter?
□ Yes □ No

What pronouns do you use? **Only if over 18 years of age
□ he/him □ she/her □ they/them □ Chose not to disclose

Pt ID # _____

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Preferred Pharmacy Name: _____ Phone: _____ Address:	**Primary Dental Provider** Name: _____ Phone: _____ Address:
Emergency Contact: Name: _____ Relationship:_____ Phone:	**Primary Care Provider (PCP)** Name: _____ Phone: _____ Address:

AS A PATIENT, I AGREE TO THE FOLLOWING:

CONSENT TO TREATMENT, AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS AND PATIENT RIGHTS AND RESPONSIBILITIES:

I. I hereby consent and authorize Community Health Center of Central Wyoming (CHCCW) to furnish me or the above registered patient with necessary medical or dental care. This care may include ancillary care including but not limited to laboratory testing, radiologic examinations and other diagnostic procedures as deemed necessary by the professional staff at CHCCW. I understand that the services recommended to, or provided to me are in my, or the registered patient's best interest. I understand that I have and reserve the right to revoke this consent at any time and for any reason during my treatment at CHCCW. I consent to be contacted by mail, email, and telephone regarding matters related to my treatment or patient account by CHCCW and entities formally associated with CHCCW.

II. I authorize CHCCW to release protected health information to persons or entities directly associated with and engaged in carrying out a treatment plan for the patient. 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 consent for CHCCW to use technology, including automated technology such as auto-dialing or pre-recorded messages, to contact me at the address, e-mail address, or telephone number, including any cell phone/wireless number that I have provided; I understand that this information will be used to review, investigate, make payment of a claim, to review records for quality improvement initiatives, audit compliance, utilization management, or complaint resolution. I authorize payment directly to Community Health Centers of Central Wyoming for all medical or dental 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 my account at Community Health Centers of Central Wyoming account may be applied to my patient balance.

III. BY INITIALING EACH LINE BELOW, I SIGNIFY MY UNDERSTANDING AND AGREEMENT:

_____ I will treat the staff and clients of CHCCW with dignity and respect. Verbally expressed profanities and vulgarities toward any staff or other patients of CHCCW will not be tolerated and could be grounds for service termination.

_____ I will make every attempt arrive to my appointment on time.

_____ I will make every attempt to 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 that I am expected to make every attempt to pay any payment due, copayment, or coinsurance amount at the time of service, but understand that an inability to pay will never prevent me from being treated at CHCCW.

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

Pt ID # _____