COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
CASPER • DUBOIS • RIVERTON

PATIENT REGISTRATION FORM

5000 Blackmore Road Casper, Wyoming 82609

We are your *health*

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**	**Are you interested in accessing our patient portal? □ Yes □ No**	

RESPONSIBLE PARTY INFORMATION

First/Last Name	**Employer**	**Social Security #**
Mailing Address **City** **State** **Zip**	**Patient's Relation to Responsible Party** □ Self □ Child □ Spouse □ Parent/Guardian □ Other (please list) _____	
Date of Birth:	**Phone Number**	**Sex:** □ Male □ Female □ Decline
Insurance Company	**Employer**	**Policy/Member ID #**
Policy Holder Name	**Policy Holder DOB**	**Policy Holder Social Security Number**

HEALTH CENTER FUNDING INFORMATION

In order to continue the variety of services that we offer 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) _____

Are you in need of financial assistance YES □ NO □

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

Homeless Status:
□ **Yes** □ **No**
□ Shelter □ Street
□ Transitional Housing
□ Doubling up

Agricultural Status over the last 3 years: □ No
□ Migrant □ Seasonal
□ Chose not to disclose

Student Status:
□ Student full time
□ Student part time
□ Not a Student

Employment Status:
□ Employed full time
□ Employed part time
□ Unemployed
□ Retired
□ Disabled
□ Chose not to disclose

Employer Name:
_____

Employer Address:
_____

Racial Group(s):
□ African American/Black
□ Asian
□ Caucasian/White
□ More than 1 race
□ Native American/Alaskan Native
□ Pacific Islander
□ Native Hawaiian
□ Other:
□ Chose not to disclose

Referral Source:
□ Billboard
□ Radio
□ Business/Agency
□ Friend or Family
□ Fair/Festival/Event
□ Hospital/Clinic
□ Internet Search
□ Social Media
□ Newspaper
□ Chose not to disclose

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

Preferred Language:
_____

Do you need an Interpreter?
□ Yes □ No

Ethnicity:
□ Hispanic/Latino/Latina
□ Non-Hispanic/Latino/Latina
□ 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 pronouns do you use?
****Only if over 18 years of age**
□ he/him
□ she/her
□ they/them
□ Chose not to disclose

Primary Care Provider (Medical)	Preferred Pharmacy	
Dental Provider	Do you have an Advance Directive/Living Will/Power of Attorney? Yes □ No □	
Emergency Contact	**Relationship to Patient**	**Phone Number**

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