COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
CASPER • DUBOIS • RIVERTON

Account # _____

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**	**School Name**	
Primary Care Provider		**Dental Provider**	

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 #**

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

The information given on this form is true to the best of my knowledge.

I, _____, parent or legal guardian of _____, do hereby authorize a sports physical examination at Community Health Center of Central Wyoming. I understand that this service is offered at no out of pocket cost as a Health Fair benefit to the community. I authorize payment directly to Community Health Center of Central Wyoming for Health Fair benefits rendered otherwise payable to me under the terms of my insurance. CHCCW may use and release any part of my medical records necessary to process billing of third party payers for services rendered on my behalf. I clearly understand that all of my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim. A photocopy of this authorization shall be considered as effective and as valid as the original. I understand that no other evaluation, diagnosis, or treatment will be provided during this exam, to include but not limited to immunizations or acute illness. Any follow up appointments must be scheduled at later dates with a primary care provider. In signing below, I certify that I have received and/or reviewed the Notice of Privacy Practice (HIPAA) Form.

Signed: **X**_____ _____
(Please Circle One) Patient Signature/Parent/Legal Guardian Signature Date

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: _____