Patient Registration Form

Today's Date:___________________________________

Legal Name (Name on Legal Documents)

Last: _____________________________ **First:**_____________________________ **Middle Initial:** ___

Name you like to be called: __________________________ **Pronoun(s):** __________________________

While WCHC recognizes a number of sexes/genders, many insurance companies and legal entities do not. Please be aware that your legal name and sex listed on your insurance card must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different, please be sure to include them in the space above.

Legal Sex (Sex on Legal Documents)
Male [ ] or Female [ ]

Sex Assigned at Birth
Male [ ] or Female [ ]

Gender Identity: Choose the one that best describes you
[ ] **Male** [ ] **Female**
[ ] **Transgender Male (FTM)** [ ] **Transgender Female (MTF)**
[ ] **Genderqueer/nonbinary**
[ ] ____________________ [ ] **Choose not to share**

Date of Birth: __________________________

Home Phone: ___________________________
Ok to leave message [ ] Brief [ ] or Extended [ ]

Cell Phone: _____________________________
Ok to leave message [ ] Brief [ ] or Extended [ ]

Email Address: ____

Mailing Address
Street:____________________________ **Unit #:** __ **City:** ________________ **State:** ____ **Zip:** __________

Physical Address (if different)
Street:____________________________ **Unit #:** __ **City:** ________________ **State:** ____ **Zip:** __________

Responsible Party: [ ] **Self** [ ] **Spouse** [ ] **Parent** [ ] **Other– relationship to patient?** ____________
Last: _____________________________ **First:**_____________________________
Date of birth: _____________________ **Contact #:** ________________________

Emergency Contact
This is the person you would like called should an emergency happen.
This person does not have the authority to make medical decisions on your behalf.

Name: ____ **Contact #:** _____________________________
Relationship to patient:______________________________________

Income Information
Gross household income: $_________________________ [ ] **Monthly or** [ ] **Annual**
Total persons in family/household (including self): __________________________
Are you/your dependents insured? [ ] **Yes** [ ] **No**

Preferred Pharmacy
Name: ____
City: __________________________ **Street:** __________________________

The following information is for demographic purposes only and will not affect your care.

Race (check all that apply)
[ ] American Indian/Alaska Native
[ ] Asian
[ ] Native Hawaiian
[ ] Black or African American
[ ] White
[ ] Other Pacific Islander
[ ] Decline to Specify

Primary Language (s):
____
Translation needed? [ ]

Ethnicity
[ ] Hispanic or Latino
[ ] Not Hispanic or Latino
[ ] Decline to Specify

Veteran Status
[ ] Veteran
[ ] Not a Veteran
[ ] Decline to Specify

Agricultural Worker Status
[ ] Migratory Agricultural Worker
[ ] Seasonal Agricultural Worker
[ ] Not an Agricultural Worker
[ ] Decline to Specify

Sexual Orientation
[ ] Lesbian or Gay
[ ] Straight
[ ] Bisexual/Pansexual
[ ] Don't Know
[ ] ______________________
[ ] Choose not to disclose

Current Housing Status
[ ] I have housing

[ ] Have you been homeless in the last 12 months?
Yes No

[ ] I do not have permanent housing currently
Where have you been living?
[ ] Doubling up with someone
[ ] Street/Camping or car
[ ] Transitional housing
[ ] Permanent Supportive Housing

By signing below, I declare under penalty of perjury that the information I have given on this form is true, correct and complete.

Signature of Patient/Guardian: ________________________________ **Date:** _________________

If patient/guardian unable to sign:
Signature of witness: ____ **Date:** _________________
Relationship to patient: ______________________________________

FOR OFFICE USE ONLY

West County Health Centers is dedicated to providing high quality primary health care to our entire community. Part of doing that is getting started with a good understanding of the 'ground rules' of providing you with that care.

To provide you with treatment, and bill your insurance for those services, we need you to read this entire form and sign below to show that you agree with the following statements. If you have any questions, please ask them before you sign this form.

Consent to Treatment	By signing below, I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself and my family while a patient at West County Health Center. WCHC provides integrated primary care and uses an integrated electronic health record system meaning that information may be shared and portions of your records are viewable by healthcare personnel working collaboratively to support your care
Providers in training	West County Health Centers sometimes has nurses, physicians, and other healthcare providers in training working with and under the supervision of West County Health Centers employees and providers. By signing below, you agree that these trainees can be present while you are being cared for at West County Health Centers.
Payment for Services	By signing below, you agree to pay for services provided by West County Health Centers at the time they are rendered, including your co-payment, co-insurance, or deductible; unless some other arrangement is agreed to by West County Health Centers. You also agree that you are responsible for all charges, whether or not some part of them is paid by insurance. If you do not pay for services, by signing below you agree that you will pay all costs of collecting that unpaid amount from you, including reasonable attorneys' fees.
Insurance Assignment of Benefits	By signing below and providing us with your insurance information, you approve West County Health Centers submission of claims to your insurance plan, Medicare, Medi-Cal, or any other insurance plan or program that may pay for your care. You also assign the benefits from such insurance or programs to West County Health Centers and agree that the benefits can be paid directly to West County Health Centers. You also agree to cooperate with West County Health Centers in filing such claims and provide us with any changes to information related to you, your eligibility or coverage under a particular policy or program.
Financial Assistance	West County Health Centers has sliding/reduced medical fee program based on family income. To apply for this, you must provide proof of you income, such as pay stubs, unemployment benefit awards, AFDC, tax returns, alimony checks, pension statements, etc. By signing below, you agree that West County Health Centers has provided you with notice about this policy.
Pharmacy History (optional)	I hereby authorize West County Health Centers, Inc. permission to view my prescription history from external sources. _______(initials)
Notice of Privacy Practices	West County Health Centers is committed to protecting your personal health information in compliance with the law. The full notice of privacy is available upon request and states: • Our obligations under the law with respect to your personal health information. • How we may use and disclose the health information that we keep about you. • Your rights relating to your personal health information. • Our rights to change our notice of privacy practices. • How to file a complaint if you believe your privacy rights have been violated. • The conditions that apply to uses and disclosures not described in this notice. • The person to contact for further information about our privacy practices. ☐ Patient declined to receive copy of Notice of Privacy Practices
A copy of this form	You are entitled to a copy of this form once you have signed it-just ask us.
WCHC Patients' Rights and Responsibilities and Grievance Procedure	I, ________________________________, hereby acknowledge that I have received a copy of the WCHC Patients' Rights and Responsibilities and Grievance Procedure document and have had my questions answered.
Signature	____ ______________________________ Patient or Patient Representative Date Representative-Parent, Guardian, Power of Attorney (circle which)