Senior & Residential Care Program

a Service of Community Health of Central Washington

Phone: (509)574-6139 Fax: (509)574-6138

Assisted Living / Adult Family Home
Patient Registration Form

Name of facility where patient lives: _____

Patient's Information

Patient's Name: _____ DOB: _____ _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Gender: _____ Email Address: _____

Patient's Marital Status: _____ □ Single □ Married □ Divorced □ Widow □ Separated

Guarantor's Information

Name: _____ DOB: _____ Gender: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone _____ Cell Phone: _____ Work Phone: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Do you receive care from another clinician? □ Yes* □ No

***If you checked "Yes", please provide us with the names of the clinicians below.**

_____

If over 18 years old

Advance Directive in place? □ Yes* □ No □ Living Will □ DPOA □ DNR □ POLST

***If you checked "Yes", please provide us with a copy of the document**

Do you want more information regarding the Advance Directive? □ Yes □ No

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We appreciate that you selected us as your health care provider. We provide services to people with insurance, those with not enough insurance, and those without health insurance. Our clinic receives funding from the government that requires we collect and report information about our patient population; therefore we need you to answer the following questions:

What is your current household monthly income? (See chart below) _____

Mark on the line where your household monthly income would be_____

$----------$7500 and over

↑ $500 ↑ $1,000 ↑ $2,000 ↑ $3,000 ↑ $4,000 ↑ $5,000 ↑ $6,000 ↑ $7000

Please provide copies of current insurance cards.