Ellensburg Dental Care

a Service of Community Health of Central Washington

Patient's Name _____ Medical Record #_____

Please Print Patient Registration Form: New _____ Update _____

Patient Information / Parent or Guardian

First Name	Middle Name	Last Name	Suffix

Current Home Address	Street	City	State	Zip

Mailing Address (If different from above)	Street/PO Box	City	State	Zip

Preferred Phone ( )	Secondary Phone # ( )	Social Security #

Gender ❑ Female ❑ Male	Birth Date	Email Address

Family Members

First Name	Middle Name	Last Name	Birth Date	SSN	Relationship
First Name	Middle Name	Last Name	Birth Date	SSN	Relationship
First Name	Middle Name	Last Name	Birth Date	SSN	Relationship
First Name	Middle Name	Last Name	Birth Date	SSN	Relationship

Language

What is your primary household language?

❑ English ❑ Spanish ❑ Other _____

Do you need assistance with reading or writing? ❑ Yes ❑ No

Would you like an interpreter provided during your appointment? ❑ Yes ❑ No

Marital Status

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow ❑ Domestic Partner

Who can we contact in case of emergency?

Name	Phone	Relationship
Name	Phone	Relationship

About Your Work

❑Currently working ❑Currently Not working ❑Work for Myself ❑Student ❑In Military ❑Retired

If currently working – Employer Name: Telephone ( )

Address	City	State	Zip

Revision: 9/23/11

What type of health Insurance do you have?

❑Private Insurance **Medicaid:** ❑Regence Healthy Options ❑Molina ❑CHPW ❑Open
❑Medicare ❑No Insurance ❑Other _____

Medicaid Provider One ID #

Private
Insurance Name Insurance ID # Insurance Group #

Subscriber First Name Last Name Birth Date SSN

Mailing Address Street City State Zip

Phone ( ) Relationship to Patient:

Secondary
Insurance Name Insurance ID # Insurance Group #

Subscriber First Name Last Name Birth Date SSN

Mailing Address Street City State Zip

Phone ( ) Relationship to Patient:

If you are a new patient, how did you hear about us?

❑ Newspaper ❑ Radio/TV ❑ Friend/Family ❑ Yellow Pages ❑ Internet ❑ Event
❑ Walked/Drove By ❑ Physician Referral

Privacy Restrictions

Is it okay to send mail to your mailing address and/or call or leave a message about your health care (including test results)? ❑ Yes ❑ No If no, please list another Contact Person, Relationship, Address & Phone:

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 that we collect and report information about our patient population; therefore we need you to answer the following questions.

Ethnicity

❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino ❑Don't know

Which of the following groups do you feel you belong to? *Select one or more of the following:*

❑African American ❑Asian ❑Native American/Alaskan ❑Native Hawaiian
❑Pacific Islander ❑White/Caucasian ❑More Than One Race ❑Don't Know

Veteran Status

Are you a Veteran of the U.S. Military? ❑ Yes ❑ No

Experience with Agriculture (Farm Work)

1. In the past 2 years have you or anyone in your family worked in any type of agriculture (farm work) like: Preparing, irrigating, or spraying the fields, nurseries, orchards; planting, picking, sorting, packing or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay or other agricultural products; planting trees; working with Christmas trees; picking pine needles or Spanish moss; taking care of chickens, ducks, turkeys, cows, goats, sheep, fish, clams, etc. or doing any other types of farm work, etc. ❑ Yes ❑ No
2. In the last 2 years, have you or a member of your family moved to another area and lived away from home in order to work in any type of agriculture (farm work)? ❑ Yes ❑ No
3. Have you or a member of your family stopped working in agriculture (farm work) because of a disability or age (too old to do the work)? ❑ Yes ❑ No

For office use only: (YES to # 1 and #2 = **Migrant**) (YES to #1 and NO to #2 = **Seasonal)** (YES to #3 = **Aged/Disabled**) (NO to all three = **Non-farmworker**)

Current Living Situation

Please select the option that best describes your current living arrangement.

❑ Own/rent house or apartment ❑ Living with friends or relatives ❑ Living in a car
❑ Living on the street ❑ Living in a Shelter ❑ Other arrangements

Household Size and Monthly Income

How many people are living in your household?	**Monthly Gross Income** (Estimate) (Amount you and the people living with you make every month before taxes)?

Authorization and Consent

- I consent that I am presenting at a clinic of Community Health of Central Washington for examination, diagnosis and /or treatment of my health, medical or dental condition.
- I give consent and authorize my provider/clinician(s) or his or her designees to order and/or perform all exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my health, medical or dental condition.
- This consent is valid for each visit I make to a clinic of Community Health of Central Washington unless revoked by me in writing.
- I authorize and request my insurance company to pay directly to Community Health of Central Washington benefits otherwise payable to me.
- I understand that my medical and/or dental insurance carrier may pay less than the actual bill for services and that I am financially responsible for all charges for services rendered to me or my dependents, including the balance remaining after payment of possible insurance benefits, deductibles and applicable co-payments.
- I have received the Notice of Privacy Practices: Signed:_____

Signature

Patient/Parent/Guardian _____

Date: _____