Community Health of Central Washington

Assisted Living/Adult Family Home
Patient Registration Form

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: ______________________

What pharmacy will you be using: ____

Insurance carrier:____

Please send copies of all insurance cards

AUTHORIZATION AND CONSENT

Authorization and Consent

- **I consent that I am being seen by a provider 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 from a Community Health of Central Washington provider 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:**

Signature

Patient/Healthcare Decision Maker: ____

**Date: ________________________

Community Health
of Central Washington

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Patient/Healthcare Decision Maker: ____

Date: ______________________________