Community Health of Central Washington

Patient Registration Form

Patient's Information

Patient's Name: _____ DOB: _____ Medical Record #: _____
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
Patient's Work Status: □ Full Time □ Part Time □ Not Employed □ Self Employed □Student
□ Military □ Retired
If currently working – Employer Name: _____ Phone: _____

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:

How many people live in your household? _____
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

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What is your primary language? _____
Is the patient Hispanic? (Check one) □ Yes □ No

Which of the following group(s) does the patient belong to? (Check only one)

□ Black/African American □ Asian □ American Indian/Alaska Native
□ Native Hawaiian □ Other Pacific Islander □ Refused to Report/Unreported
□ More than one race □ White

If over 13 years old

Gender Identity:

□ Male □ Female □ Transgender Male/Female-to-Male □ Transgender Female/Male-to-Female
□ Other □ Choose not to disclose

If over 13 years old

Sexual Orientation:

□ Lesbian or gay □ Straight (not lesbian or gay) □ Bisexual □ Something else □ Don't Know □ Choose not to disclose

Interpreter needed? (Check one) □ Yes □ No
Assistance Needed with reading or writing? (Check one) □ Yes □ No
If 18 years or older, is the patient a Veteran? (Check one) □ 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 disability or age (too old to do the work)? _____Yes _____No

Patient's current living situation:

□ Own/Rent house or apartment (non-homeless) □ In between Housing □ Homeless
□ Halfway House/Transitional Housing □ Homeless shelter

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**)

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Patient's Name: _____ DOB: _____ Medical Record #: _____

AUTHORIZATION AND CONSENT

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:**

Signature
Patient/Parent/Guardian _____

Date: _____