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Patient Registration

PATIENT INFORMATION				
Legal Last Name	**First Name**	**M.I.**	**Preferred Name**	**Date of Birth**

Legal Sex (Please CHECK ONE)*

☐Male ☐Female ☐Choose not to disclose

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Physical Address	**City**	**State**	**Zip Code**
Mailing Address	**City**	**State**	**Zip Code**

Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:

☐Home Phone ( ) -

☐Cell Phone ( ) -

☐Day Phone ( ) -

☐E-Mail Address

Marital Status
☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Do You Need An Interpreter? ☐Yes ☐ No

Primary or Preferred Language: ☐English ☐Other: _____

Housing Status: ☐Not Homeless ☐Homeless: ☐Doubling Up ☐Shelter ☐Street, Beach, Etc. ☐Transitional ☐Unreported

Ethnicity:

☐Cuban
☐ Hispanic/Latino
☐ Mexican, Mexican American, Chicano
☐ Not Hispanic/Latino
☐ Puerto Rican

Farmer Status: ☐N/A ☐Migrant ☐Seasonal

Active Military:	☐ Yes	☐ No
Veteran:	☐ Yes	☐ No
Military Spouse:	☐ Yes	☐ No
Military Dependent:	☐ Yes	☐ No

Race (CHECK ONE below that best describes you):

☐African American/Blank
☐American Indian or Alaska Native
☐Asian Indian
☐Caucasian/White
☐Chamorro
☐Chinese
☐Chuukese
☐Filipino
☐Guamanian
☐Japanese
☐Korean
☐Laotian
☐Marshallese
☐Micronesian
☐Native Hawaiian
☐Other Pacific Islander (Yap, Kosrae, Pohnpei, Palau)
☐Samoan
☐Thai
☐Tongan
☐Vietnamese

Employer/School Name:	☐Employed ☐Unemployed ☐Student ☐Retired	☐Full-Time ☐Part-Time ☐Casual
Occupation:	**Family Size** (includes self, spouse, & children under 18): _____	**Family Income:** $ _____ ☐Monthly ☐ Annual

Wahiawā Health

Patient Registration

PARENT/LEGAL GUARDIAN or GUARANTOR INFORMATION					
Relationship of Guarantor to Patient (Check One): ☐ Self ☐Spouse ☐Parent ☐ Other: _____					
Legal Last Name	**First Name**	**M.I.**	**Preferred Name**		**Date of Birth**
Physical Address		**City**		**State**	**Zip Code**
Mailing Address		**City**		**State**	**Zip Code**
Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:					
☐Home Phone ( )	☐Cell Phone ( ) -	☐Day Phone ( ) -	☐Email Address		
Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed	**Do You Need An Interpreter?** ☐Yes ☐ No	**Primary or Preferred Language:** ☐English ☐Other: _____			
Employer Name:	☐Employed ☐Unemployed ☐Student ☐Retired	☐Full Time ☐Part time ☐Casual			
Occupation:	**Family Size** (includes self, spouse, & children under 18): _____	**Family Income:** $ _____ ☐ Monthly ☐ Annual			

Wahiawā Health

Patient Registration

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:		**Relationship:**
Home Phone	**Work Phone**	**Cell Phone**

PATIENT PORTAL

Patient Portal *is WHC's latest technology that allows you to schedule and view appointments, request medication refills, see lab results, communicate with your health care team, ask questions about your bill, and request your health record.*

Are you enrolled into Patient Portal? ☐ Yes ☐ No **If No, do you need assistance to enroll?** ☐ Yes ☐ No

ADVANCE DIRECTIVES

Do you have an Advance Directive? *(Form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are not able to respond)* ☐ Yes ☐ No

MARKETING & PROMOTIONS

How did you hear about us? (Check all that apply)	☐ Family/Friends	☐ Mailer	☐ Web Search	☐ Banner
	☐ Social Media	☐ Print Ads	☐ Other (Please specify): _____	
How do you want to stay updated on services and classes? (Check all that apply)	☐ Email	☐ Phone Call	☐ Patient Portal	
	☐ Text Message	☐ Mailer	☐ Other (Please specify): _____	

_____ Initials

I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby authorize WHC to release information to my insurance carrier or organization to process claims on my behalf. I authorize payment of benefits to WHC for services rendered.

_____ Initials

I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials

I authorize WHC to communicate via text, email, and phone call. Message & Data rates may apply. If I am not available, I give WHC consent to communicate a message which will identify the WHC service(s) and/or the date and time of my appointment(s). I may opt out at any time and will need to notify the Front Office.

Patient was informed of Wahiawa Health Center's Rights & Responsibilities. Information is available on

_____ Initials

WHC's website and patient may request a hard copy at any time.

_____ Initials

Patient was informed of Wahiawa Health Center's Notice of Privacy Practices. Information is available on WHC's website and patient may request a hard copy at any time.

_____ _____

Patient or Legal Guardian's Signature Date Signed

_____ _____

Guarantor's Signature Date Signed

FOR OFFICE USE ONLY

Record #_____

Pt Status Type: ☐ Inactive ☐ Scheduled ☐ Non-WHC Active ☐ Active ☐ Dental Patient Only	**Valid ID:** ☐ Scan ID ☐ Update NG Pt Picture	**Insurance:** ☐ Scan Card ☐ Update Info/Card

Collected By: _____ Date: _____

Entered By: _____ Date: _____

Wahiawā Health

Patient Registration: INSURANCE

PRIMARY MEDICAL INSURANCE INFORMATION				
Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____				
Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Unknown** ☐ **Female**		
Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**
Home Address	**City**	**State**	**Zip Code**	
Home Phone	**Work Phone**	**Cell Phone**		

SECONDARY MEDICAL INSURANCE INFORMATION				
Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____				
Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Unknown** ☐ **Female**		
Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**
Home Address	**City**	**State**	**Zip Code**	
Home Phone	**Work Phone**	**Cell Phone**		

Outpatient Consent for Care

I,_____, the undersigned, hereby give Wahiawa Health Center my consent and permission to obtain historical information, perform physical examinations, order diagnostic tests and give such treatment as the Center physicians deem appropriate for my physical and/or mental health. I understand that this consent is for, but not limited to, obtaining detailed medical and social/psychiatric histories, performance of examinations of mouth, genitals, rectum and ears, repair of minor cuts, tuberculin skin tests, injection of local anesthetics and medications (such as insulin, epinephrine, etc.), injection of immunizations, and all other ordinary medical office procedures.

I understand that for major procedures (such as incision and drainage of abscesses, biopsies, or insertion of such devices as an IUD or LARC) special explanations will be made to me and special permission obtained from me or from an adult family member if I am physically or mentally impaired from giving such consent. In cases of emergency, I hereby give permission for the rendering of all such medical services deemed necessary to stabilize my condition if I am physically or mentally impaired and an adult family member is not readily available.

This consent is for the ongoing health care of myself until I withdraw from the Wahiawa Health Center and is given voluntarily. By my signature I hereby certify that I am of legal age (18 years old or older) or am an emancipated minor by the definition of State laws.

I certify that I have read the above (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed.
Exceptions:

_____

_____

_____
Patient or Legal Guardian Signature

_____
Date

I authorize the following person to have access to my medical records, schedule appointments on my behalf and consent to any examination, x-rays, anesthetic, medical diagnosis, immunization, or treatment rendered.

_____ (Name)	_____ (Relationship)
_____ (Name)	_____ (Relationship)
_____ (Name)	_____ (Relationship)
_____ (Name)	_____ (Relationship)
_____ (Signature of Parent or Legal Guardian)	_____ (Date)