



MINOR 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? (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.

Initials

MINOR: I consent and authorize Wahiawa Health Center to provide medical services including but not limited to immunizations and screenings for my son/daughter/ward.

Initials

Patient was informed of Wahiawa Health Center's Rights & Responsibilities. Information is available on 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: <input type="checkbox"/> Inactive <input type="checkbox"/> Scheduled <input type="checkbox"/> Non-WHC Active <input type="checkbox"/> Active <input type="checkbox"/> Dental Patient Only	Valid ID: <input type="checkbox"/> Scan ID <input type="checkbox"/> Update NG Pt Picture	Insurance: <input type="checkbox"/> Scan Card <input type="checkbox"/> Update Info/Card
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Collected By: _____ Date: _____

Entered By: _____ Date: _____



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PRIMARY MEDICAL INSURANCE INFORMATION										
Patient's Relationship to the Insured (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Step-Child <input type="checkbox"/> Child <input type="checkbox"/> Other: _____										
Policy Holder Name					Date of Birth			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Unknown
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): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Step-Child <input type="checkbox"/> Child <input type="checkbox"/> Other: _____										
Policy Holder Name					Date of Birth			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Unknown
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: MINOR

I, _____, the undersigned, hereby give Wahiawa Health Center to examine my (son/daughter/ward):

Child's Name

Date of Birth

to make such tests as are necessary for his/her diagnosis and care, and to give such treatment as the Wahiawa Health Center physicians and nurse practitioners deem necessary. This includes diagnosis and care at Wahiawa Health Center, School Based Health clinics, and offices of specialists, and psychological tests.

WHC will inform the parent/legal guardian before starting or making any change the minor patient's medications without first speaking to a parent/legal guardian.

This consent which I am signing is for the ongoing health care of my (son/daughter/ward) until I withdraw him/her from the Center. I understand that it includes consent for general tests, tuberculin tests, applications to skin or mucous membranes, examination of mouth, genitals, rectum, and ears, repair of small cuts, and all other ordinary medical office procedures.

I certify that I have read (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:

Parent/Legal Guardian Signature

Date

I authorize and consent to any medical and or behavioral care rendered by the Wahiawa Health Center in the event that my child(ren) is brought to the Center by the following persons:

(Name)

(Relationship)

(Name)

(Relationship)

(Name)

(Relationship)

(Name)

(Relationship)

(Signature of Parent or Legal Guardian)

(Date)