WesternU Health
Oliver Station

New Patient Registration

PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**
Preferred Name:	**Date of Birth:**	**SSN:**
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Mobile Phone:**	
Work Phone:	**Email:**	

We require the following information for the purpose of helping our staff use the most respectful language when addressing you and understanding our patient population better. Please help us serve you better by selecting the best answers to these questions. Thank you.

Sexual Orientation:
- ❑ Straight/Heterosexual
- ❑ Bisexual
- ❑ Gay
- ❑ Lesbian
- ❑ Pansexual
- ❑ Queer
- ❑ Omnisexual
- ❑ Asexual
- ❑ Choose not to disclose

Gender Identity:
- ❑ Female
- ❑ Male
- ❑ Transgender Female/Male to Female
- ❑ Transgender Male/Female to Male
- ❑ Non-binary/genderqueer
- ❑ Other:_____
- ❑ Choose not to disclose

Sex Assigned at Birth:
- ❑ Female
- ❑ Male
- ❑ Intersex
- ❑ Not Recorded on Birth Certificate
- ❑ Choose not to disclose

Pronouns:
- ❑ Patient Name
- ❑ She/Her/Hers
- ❑ He/Him/His
- ❑ They/Them/Theirs
- ❑ Other: _____
- ❑ Decline to Answer

Marital Status:
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Legally Separated
- ❑ Significant Other
- ❑ Widowed
- ❑ Unknown
- ❑ Other:_____
- ❑ Decline to Answer

Race:
- ❑ Alaskan Native
- ❑ American Indian
- ❑ Asian:_____
- ❑ Black/African American
- ❑ Native Hawaiian
- ❑ Pacific Islander
- ❑ White
- ❑ Unknown
- ❑ Other:_____
- ❑ Decline to Answer

Ethnic Group:
- ❑ Hispanic, Latino/a or Spanish Origin
- ❑ Cuban
- ❑ Mexican, Mexican American
- ❑ Non-hispanic or Latino/a
- ❑ Puerto Rican
- ❑ Other:_____
- ❑ Decline to Answer

Veteran/Military Status:
- ❑ Veteran
- ❑ Active Duty
- ❑ Inactive Duty
- ❑ No
- ❑ Decline to Answer

EMERGENCY CONTACTS

If your emergency contact lives with you, please list an alternative number, other than your home phone. Minors must have a parent or legal guardian listed as their primary emergency contact.

Emergency Contact (Primary):	
Relationship:	**Phone Number:**
Emergency Contact (Secondary):	
Relationship:	**Phone Number:**

PATIENT NAME:_____ DATE OF BIRTH:_____

EMPLOYMENT

❏ Child
❏ Student
❏ Full Time
❏ Part-Time
❏ Self Employed
❏ Not Employed
❏ Retired
❏ Active Military Duty
❏ Decline to Answer

Employer:

Address:

Are you a WesternU Employee?
❏ Yes
❏ No

Are you a WesternU Student?
❏ Yes
❏ No

PATIENT ASSISTANCE

Low Vision?
❏ Yes
❏ No

If YES, do you wear glasses/contacts?
❏ Yes
❏ No

Hearing Impaired?
❏ Yes
❏ No

If YES, do you use a Hear Aid?
❏ Yes
❏ No

Special Needs:
❏ Walker
❏ Wheelchair
❏ Other: _____

Preferred Language: _____

Other Languages Spoken:_____

Interpreter Needed?
❏ Yes
❏ No

INSURANCE INFORMATION

RESPONSIBLE PARTY: Your health insurance may reimburse you for additional fees you had paid out of pocket to your healthcare provider. Some insurances pay a fixed dollar amount for procedures while others pay a percentage of the fee charged. However, it is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid by your insurance.

Primary Insurance:	**Secondary Insurance:**
Member ID:	Member ID:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:
Relationship to Patient:	Relationship to Patient:

Medicare Member ID:

ADVANCED DIRECTIVE AND POLST (Physician's Order for Life-Sustaining Treatment)

Do you have an Advanced Directive for Health Care?
❏ Yes
❏ No

Do you have a POLST?
❏ Yes
❏ No

If YES, please provide our office with a copy. If NO, would you like more information about either or both of these options?
❏ Yes
❏ No

PATIENT NAME:_____ DATE OF BIRTH:_____

CONFIDENTIAL COMMUNICATIONS

One of our goals is to protect your right to privacy; therefore, unless we have your permission, information will not be given to anyone regarding you or your finances.

May we call you at the following phone numbers?
- ❑ Home
- ❑ Mobile
- ❑ Work

Do you have an alternate number we can contact you at?
- ❑ Yes; **What is the alternate number?**_____
- ❑ No

May we send you an email?
- ❑ Yes; **What is your email?**_____
- ❑ No

May we send you text messages?
- ❑ Yes
- ❑ No

May we send you a fax?
- ❑ Yes
- ❑ No

May we leave messages (including appointment information) on your answering machine/voicemail?
- ❑ Yes
- ❑ No

We are not allowed to disclose any information, such as the results of tests, procedures, and financial information, without the patient's consent. We will only provide information about you to those you have listed below.

Name:	
Relationship:	**Phone Number:**
Name:	
Relationship:	**Phone Number:**
Name:	
Relationship:	**Phone Number:**
Name:	
Relationship:	**Phone Number:**

If you wish to have your medical or financial information released to any family members, you must sign this form. This consent is valid until otherwise notified in writing. A photocopy or electronic scan of this document shall be as valid as an original.

_____ _____

(PRINT) Name of Patient or Parent/Legal Representative **Date**

_____

(SIGNATURE) of Patient or Parent/Legal Representative

PATIENT NAME:_____ DATE OF BIRTH:_____

CONSENT AND ACKNOWLEDGEMENT

_____ **(INITIAL) CONSENT TO TREAT:** I hereby request and authorize WesternU Health to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are deemed necessary or beneficial for my health and well-being. It is understood that this consent is given in advance of specific services, but is given in order that WesternU Health may exercise their best judgement as to proper medical care, which may be necessary to protect my life.

_____ **(INITIAL) ASSIGNMENT OF BENEFITS:** I hereby assign directly to WesternU Health all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance.

_____ **(INITIAL) EXPECTED BEHAVIOR:** I understand that I am responsible for being respectful of others persons at WesternU Health. I am also aware that I am expected to treat WesternU Health faculty, staff and students with courtesy and respect. Inappropriate behavior or comments of a cultural, ethnic or sexual nature will not be tolerated and can result in me being discharged as a patient from WesternU Health.

_____ **(INITIAL) PHOTOGRAPHY:** I hereby consent to have my photo taken as part of the registration process for the purpose of patient identification in the electronic medical record.

_____ **(INITIAL) NO SHOWS:** I understand that I must cancel or reschedule any appointment at least 24 hours in advance. Consecutive missed appointments may result in termination of care due to frequent no shows.

_____ **(INITIAL) MEDICAL STUDENTS:** I understand that Western U Health is a teaching facility and has medical students rotating in the clinic that may participate in my care at the discretion of my provider and myself.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I received a copy of the WesternU Health Notice of Privacy Practices. I understand that the Notice of Privacy Practices provides information about how WesternU Health may use and disclose my health information.

_____	_____	_____
Patient Name (PRINT)	**Patient Name (SIGNATURE)**	**DATE**

If this form is completed by a patient's legal representative, please print and sign your name in the space below.

_____	_____	_____
Legal Representative (PRINT)	**Legal Representative (SIGNATURE)**	**DATE**

_____

Relationship to Patient