



PATIENT INFORMATION

Legal Last Name		First Name		M.I.	Preferred Name		Date of Birth
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Do You Need An Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary or Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____			
Legal Sex (Please check one)* <input type="checkbox"/> Male <input type="checkbox"/> Female <small>*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.</small>		Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Other <input type="checkbox"/> Chose not to disclose			Sexual Orientation <input type="checkbox"/> Lesbian, Gay or Homosexual <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Chose not to disclose		
Mailing Address				City	State	Zip Code	
Please complete and indicate your preferred contact method by checking one of the boxes below: <input type="checkbox"/> Home Phone () - <input type="checkbox"/> Cell Phone () - <input type="checkbox"/> Day Phone () - <input type="checkbox"/> Email Address							
Housing Status:		<input type="checkbox"/> Not Homeless		<input type="checkbox"/> Homeless:		<input type="checkbox"/> Doubling Up <input type="checkbox"/> Street, Beach, Etc. <input type="checkbox"/> Unreported <input type="checkbox"/> Shelter <input type="checkbox"/> Transitional	
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		Farmer Status: <input type="checkbox"/> N/A <input type="checkbox"/> Seasonal <input type="checkbox"/> Migrant		Active Military or Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Race (pick one below that best describes you): <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian <input type="checkbox"/> Chinese <input type="checkbox"/> Chuukese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Marshallese <input type="checkbox"/> Micronesian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Portuguese <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> All Other (please specify): _____							
Employer:		Occupation:		Family Size (includes self, spouse, & children under 18): _____		Family Income: <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$	
PARENT OR LEGAL GUARDIAN INFORMATION							
Relationship of Guarantor to Patient (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____							
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EMERGENCY CONTACT INFORMATION							
Emergency Contact Name:					Relationship:		
Home Phone			Work Phone		Cell Phone		

PRIMARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____					
Policy Holder Name			Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female
Plan Name		Policy # / Subscriber #	Group #	Effective Date:	Expiration Date:
Home Address			City	State	Zip Code
Home Phone		Work Phone		Cell Phone	

_____ I hereby authorize WHC to release information to my insurance carrier in order to process claims on my behalf. I authorize
 Initials payment of benefits to WHC for services rendered.

_____ 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
 Initials form with facts I know are false or to leave out facts I know are important.

_____ I understand that I can review a Notice of Privacy Practices upon request at the time of vaccination.
 Initials

 Patient Signature Date Signed Signature of Parent/Legal Guardian Date Signed

FOR OFFICE USE ONLY

MEDICAL SERVICES – Record # _____					
Pt Status Type: <input type="checkbox"/> Scheduled <input type="checkbox"/> Non-WHC Active <input type="checkbox"/> Inactive <input type="checkbox"/> Dental Patient Only		Valid ID: <input type="checkbox"/> ID Scanned <input type="checkbox"/> NG Pt Picture Updated		Insurance: <input type="checkbox"/> Card Scanned <input type="checkbox"/> Info/Card Updated	
Collected By: _____ Date: _____			Entered By: _____ Date: _____		