WAIMĀNALO HEALTH CENTER

Patient Registration: ECV OUTREACH

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

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

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Legal Sex (Please check one)* ☐ Male ☐ Female

*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.

Gender Identity
☐ Male
☐ Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other
☐ Choose not to disclose

Sexual Orientation
☐ Lesbian, Gay or Homosexual
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't know
☐ Choose not to disclose

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

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

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Farmer Status: ☐ N/A ☐ Migrant ☐ Seasonal

Active Military or Veteran: ☐ Yes ☐ No

Race (pick one below that best describes you):
☐ African American/Black ☐ White ☐ Chinese ☐ Chuukese ☐ Filipino ☐ Guamanian
☐ Japanese ☐ Korean ☐ Laotian ☐ Marshallese ☐ Micronesian ☐ Native American
☐ Native Hawaiian ☐ Portuguese ☐ Puerto Rican ☐ Samoan ☐ Tongan ☐ Vietnamese
☐ Other Asian ☐ Other Pacific Islander ☐ All Other (please specify): _____

Employer:	Occupation:	Family Size (includes self, spouse, & children under 18): _____	Family Income: $ ☐ Monthly ☐ Annual

PARENT OR LEGAL GUARDIAN INFORMATION

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

_____ Initials

I hereby authorize WHC to release information to my insurance carrier in order 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 understand that I can review a Notice of Privacy Practices upon request at the time of vaccination.

_____ Patient Signature Date Signed

_____ Signature of Parent/Legal Guardian Date Signed

FOR OFFICE USE ONLY		
MEDICAL SERVICES – Record #_____		
Pt Status Type: ☐ Inactive ☐ Non-WHC Active ☐ Scheduled ☐ Inactive ☐ Dental Patient Only	**Valid ID:** ☐ ID Scanned ☐ NG Pt Picture Updated	**Insurance:** ☐ Card Scanned ☐ Info/Card Updated
Collected By: _____ Date: _____	Entered By: _____ Date: _____	