WAIMĀNALO HEALTH CENTER

Patient Registration: ECV OUTREACH

PATIENT INFORMATION

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

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ 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
- ☐ Chose not to disclose

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

☐ 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/School:	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: ________________________

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

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone	☐ Cell Phone	☐ Day Phone	☐ Email Address

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: ☐ Scheduled	☐ Inactive ☐ Inactive	☐ Non-WHC Active ☐ Dental Patient Only	**Valid ID:**	☐ ID Scanned ☐ NG Pt Picture Updated	**Insurance:** ☐ Card Scanned ☐ Info/Card Updated
Collected By: ___________________	Date: _________		Entered By: ___________________	Date: _________	

WAIMĀNALO HEALTH CENTER

PARENT AUTHORIZATION & CONSENT FORM

I, ______________________________, the ______________
(Parent or Legal Guardian) (Relationship)

of ______________________________ ______________ and
(Minor's Full Legal Name) (Birthdate)

of ______________________________ ______________ and
(Minor's Full Legal Name) (Birthdate)

of ______________________________ ______________ and
(Minor's Full Legal Name) (Birthdate)

of ______________________________ ______________ and
(Minor's Full Legal Name) (Birthdate)

of ______________________________ ______________ and
(Minor's Full Legal Name) (Birthdate)

of ______________________________ ______________
(Minor's Full Legal Name) (Birthdate)

Authorize and consent to any examinations, x-rays, anesthetic, medical diagnosis, immunization, or treatment rendered by the Waimānalo Health Center in the event that my child(ren) are brought to the Center by the following persons:

______________________________ ______________
(Name) (Relationship)

______________________________ ______________
(Name) (Relationship)

______________________________ ______________
(Name) (Relationship)

______________________________ ______________
(Name) (Relationship)

______________________________ ______________
(Signature of Parent or Legal Guardian) (Date)

Telephone number where Parents/Legal Guardians can be reached:

______________________________ ______________ ______________
Father's Name Business Phone Home Phone

______________________________ ______________ ______________
Mother's Name Business Phone Home Phone

______________________________ ______________ ______________
Legal Guardian's Name Business Phone Home Phone