Washington Health Medical Group

PATIENT REGISTRATION

Today's Date:_____ Home Phone #_____-_____-_____ Cell Phone #_____-_____-_____

Patient's Last Name:_____ First:_____ Middle Initial:_____

SS #_____-_____-_____ Date of Birth_____/_____/_____ ☐Male or ☐Female *Status*: ☐S ☐M ☐D ☐W

Home Address:_____ Apartment Number:_____

City:_____ State:_____ Zip Code:_____ Email address:_____

Preferred Method of Contact: E-mail ☐Phone ☐Mail ☐

Occupation:_____ Employer Name:_____

Employer Address:_____ City:_____ State:_____ Zip Code:_____

Work Phone #_____-_____-_____ Emergency Contact:_____

Emergency Phone #_____-_____-_____ Relationship to Patient:_____

Referred By:_____ Primary Care Physician:_____

How did you hear about us? ☐Advertisement ☐Employer ☐Friend/Relative ☐Other: _____

Race: Please mark what best describes you. If more than one, please mark numerically in order.

☐White/Caucasian ☐American Indian/Alaska Native ☐Black/African American

☐Asian: _____ ☐Native Hawaiian/Other Pacific Islander

☐Other: _____ ☐Decline

Ethnicity: _____ Hispanic or Latino? Yes ☐No ☐

Which **Language** do you speak in your home?_____

Religion:_____ **Preferred Pharmacy**_____ **Preferred Lab**_____

PRIMARY INSURANCE: Subscriber to Insurance: ☐Self ☐Spouse ☐Parent ☐Company

Last Name:_____ First:_____ Middle:_____

Relationship to Patient:_____ SS #_____-_____-_____ Date of Birth:_____

Insurance Name:_____ Subscriber ID:_____ Group #_____

SECONDARY INSURANCE: Subscriber to Insurance: ☐Self ☐Spouse ☐Parent ☐Company

Last Name:_____ First:_____ Middle:_____

Relationship to Patient:_____ SS #_____-_____-_____ Date of Birth:_____

Insurance Name:_____ Subscriber ID:_____ Group #_____

WORKERS COMPENSATION: **Did you report the injury to your Employer? ☐Yes ☐No**

Date of Injury: / / _____ _____ Time:_____ AM/PM Claim Number:_____

Where Injury Occurred:_____

Employer Contact:_____ Contact Phone #_____-_____-_____

Worker's Comp Insurance: _____ Policy #:_____Claims Adjuster:_____

Phone: _____ Fax:_____-_____ - _____

Address:_____City:_____ State: Zip Code: _____

Brief explanation of accident and body part injured: _____

_____

_____

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CONSENT FOR TREATMENT

I consent to the treatment necessary for the above named patient. I authorize the release and/or fax of all my medical records to the referring and family physicians and to my Worker Compensation Carrier Company, if applicable. If lab or x-ray is needed, I authorize access to my medical records through the WeCare electronic medical record. I hereby authorize Washington Hospital Healthcare System (Washington Hospital, Washington Township Medical Foundation, Washington On Wheels, Washington Urgent Care, Washington Outpatient Rehabilitation Center, and Washington Radiation Oncology Center) to obtain my prescription/medication history electronically from multiple sources including pharmacies and physicians outside the practice as medically necessary for my treatment. I authorize WHHS to obtain my prescription/medication history as often as they determine necessary for my proper medical care.

FINANCIAL RESPONSIBILITY

I further authorize and request that insurance payments be made directly to Washington Hospital Healthcare Sys tem (Washington Hospital, Washington Township Medical Foundation, Washington On Wheels, Washington Urgent Care, Washington Outpatient Rehabilitation Center, and Washington Radiation Oncology Center). My signature on this form acknowledges that I agree to bear full financial responsibility for all services provided that may not be covered by my insurance for the following reasons; not a covered benefit, not referred or authorized, or determined not to be eligible for coverage with Washington Hospital Healthcare System. I am aware that there is a $25.00 fee for any appointments that I miss and had not contacted the office to cancel. I am aware that I have the right to appeal the insurance company's determination. If a denial is received, I will be responsible for the amount of this bill.

I have been offered a copy of *the Washington Hospital Healthcare System Notice of Privacy Practices*. By signing this Registration Form, I consent to the use and disclosure of my protected health information for the purpose of treatment, payment, and healthcare operations.

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying WHHS of any changes made to my contact information and/or insurance.

DATE _____ **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY** _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY _____