West County Health Centers
Caring for our Communities
a california health center

Do you need assistance completing this form?
Please check in with the front desk team for help.

Patient Registration Form

While West County Health recognizes a number of sexes/genders, many insurance companies and legal entities do not. Please answer the below with your legal name & sex registered with your insurance or legal documents for insurance & billing purposes. ***If the name you like to be called or pronouns are different from your legal name/sex/gender, please be sure to list them below.***

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Previous Name: _____ **Date of Birth:** m_____/d_____/y_____

Name you would like to be called: _____ **Pronouns:** _____

Mailing Address: _____ Apt. ____City_____ State_____ Zip_____

Home Address: _____ Apt. ____City_____ State_____ Zip_____

COMMUNICATION

What is the best way to contact you? ☐Home ☐Cell ☐Work ☐Text ☐Web Message (provide email) ☐*Alternate/Confidential #

While there are some automatic messages, we cannot change how they are sent, we will do our best to honor the best way to contact you.

Home # (_____)_____-_____ **Cell #** (_____)___-_____**Work #** (____)_____-_____*Confidential # (____)_____-_____

Can we text you? ☐Yes ☐No *Who does the alternate/confidential # belong to: _____

Email:_____@_____*(email will add you to the patient portal)*

Which # can we leave a voice message? ☐Home ☐Cell ☐Work ☐*Alternate/Confidential #

Length of Message: ☐Brief OR ☐Extended

EMERGENCY CONTACT:

Name: _____ **Relationship:** _____ Phone**#:** (_____) _____-_____

PATIENT INFORMATION

Sex at Birth: ☐Female ☐Male

Gender Identity: ☐Female/Woman ☐Male/Man ☐Genderqueer / Nonbinary ☐Transgender Female/Trans Woman ☐Transgender Male/Trans Man ☐Not listed, please specify: _____

Sexual Orientation: ☐Straight/Heterosexual ☐Lesbian or Gay ☐Bisexual / Pansexual ☐Don't know ☐Something else, please describe:_____

Language: ☐English ☐Spanish ☐Other: _____ **Interpreter Needed:** ☐Yes ☐No

Impairments and/or Disabilities: ☐Visually Impaired ☐Hearing-Impaired ☐Mobility Support Needed ☐Other, please specify: _____

PHARMACY INFO:

Primary Pharmacy: _____ City: _____ Phone: (_____) _____-_____

Secondary Pharmacy: _____ City: _____ Phone: (_____) _____-_____

Patient Registration Form

ADDITIONAL REQUIRED INFORMATION

* As a federally qualified health center we are required to collect this information. All information shared will remain confidential.

Family Size: ________________ **Family Income** (before taxes): ______________________ ☐ Monthly ☐ Annually

Have you been Homeless anytime in the past 12 months? ☐ No ☐ Yes

If yes, what type of homeless did you experience: (select ONE) ☐ Living in a shelter ☐ Living on the street or my car
☐ Staying temporarily with friends/family ☐ Living in transitional housing ☐ Living in permanent supportive housing
☐ In other homeless situation, please describe: ____

Are you a United States Veteran? ☐ Yes ☐ No

Are you a farm worker? ☐ No ☐ Migrant Worker (leave your community for work)
☐ Seasonal Worker (work on a seasonal basis within your home community)

Ethnicity: (select ONE)

☐ Another Hispanic, Latino/a, or Spanish origin ☐ Cuban ☐ Not Hispanic, Latino/a, or Spanish Origin
☐ Mexican / Mexican American / Chicano/a ☐ Puerto Rican ☐ Choose Not to Disclose Ethnicity

Race: (check all that apply)

☐ American Indian /Alaskan Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
☐ Caucasian / White ☐ African American / Black ☐ Samoan ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Other Pacific Islander

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance: ________________________________ **Insurance/Subscriber ID:** __________________________

Insured Name: _______________________________ Relationship of Insured to the Patient: ____________________________

Do you have secondary Insurance coverage? ☐ No ☐ Yes, please list name: _____________________________________

RESPONSIBLE PARTY (Guarantor)

Statement/bills will be addressed to responsible party.

Name:____ Date of Birth: m____/d____/y_______

Email:__________________________________@_________________ Relationship to Patient: _________________________

Mailing Address_______________________________________Apt.__________City________________State__Zip_________

Home Phone # (_____) ______- _______Cell # (_____) _____-________ Work Phone # (_____)_____-________

FOR MINORS ONLY:

Parent/Legal Guardian of Minor: __________________________________ Relationship to Minor: ______________________
DOB: _____/_____/______ Phone #: (_____) ______-______ Is this person a legal Medical Decision Maker for Minor? ☐ Yes ☐ No

Parent/Legal Guardian of Minor: __________________________________ Relationship to Minor: ______________________
DOB: _____/_____/______ Phone #: (_____) ______-______ Is this person a legal Medical Decision Maker for Minor? ☐ Yes ☐ No

Parent/Legal Guardian of Minor: __________________________________ Relationship to Minor: ______________________
DOB: _____/_____/______ Phone #: (_____) ______-______ Is this person a legal Medical Decision Maker for Minor? ☐ Yes ☐ No

Parent/Legal Guardian of Minor: __________________________________ Relationship to Minor: ______________________
DOB: _____/_____/______ Phone #: (_____) ______-______ Is this person a legal Medical Decision Maker for Minor? ☐ Yes ☐ No

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Patient Name: _____

Date of Birth: _ _ / _ _ / _ _ _ _

Consent to Treatment

By signing below, you agree that West County Health employees and health care providers can examine you, take specimens like blood or urine, and administer routine tests like x-rays or heart monitoring. Before more invasive tests or treatments take place, we will talk with you about their specific risks and possible benefits and may ask you to sign another form once your questions have been answered.

Providers in training

West County Health sometimes has nurses, physicians and other healthcare providers in training working with and under the supervision of West County Health employees and providers. By signing below, you agree that these trainees can be present while you are being cared for at West County Health.

Payment for Services

By signing below, you agree to pay for services provided by West County Health at the time they are rendered, including your co-payment, co-insurance or deductible; unless some other arrangement is agreed to by West County Health. You also agree that you are responsible for all charges, regardless of whether some part of them is paid by insurance. If you do not pay for services, by signing below you agree that you will pay all costs of collecting that unpaid amount from you, including reasonable attorneys' fees.

Insurance –Assignment of Benefits

By signing below and providing us with your insurance information, you approve West County Health's submission of claims to your insurance plan, Medicare, Medi-Cal or any other insurance plan or program that may pay for your care. You also assign the benefits from such insurance or programs to West County Health and agree that the benefits can be paid directly to West County Health. You also agree to cooperate with West County Health in filing such claims and provide us with any changes to information related to you, your eligibility or coverage under a particular policy or program.

Patient Bill of Rights and Responsibilities

West County Health has a Patient Bill of Rights and Responsibilities which describes your rights as a patient (including information on how to file a complaint and opting out of asynchronous dictation tools) and the responsibilities that all patients equally hold. By signing below, you acknowledge that this Bill is available online at www.wchealth.org and that you may also receive a copy at any time by requesting one from any West County Health registration staff member.

Notice of Privacy Practices

West County Health has a Notice of Privacy Practices which describes your rights and how information that you provide to us may be used to provide your healthcare. By signing below, you acknowledge that this Notice is available online at www.wchealth.org and that you may also receive a copy at any time by requesting one from any West County Health registration staff member.

_____ By initialing here, I give WCHC permission to review pharmacy records related to the health care I get.

X _____ _____

Patient Signature (parent/guardian must sign for minors and dependent adults) Today's Date

For Dependent Adults, Conservator approval is required: X_____(sign here)