Patient Information (PLEASE PRINT)

PATIENT'S PREFERRED NAME:_____ Legal Name:_____

Date of Birth:_____

Pronoun: He She They Other_____

Patient's SSN:_____(photo I.D. required) Phone #:_____

Email:_____

What name would you like to be called in the		
Waiting Room	Preferred	Legal
Exam Room	Preferred	Legal
Phone Calls	Preferred	Legal

Address:_____Apt#:_____City:_____State:_____Zip:_____

Emergency Contact Information

Name:_____Relationship:_____Phone #:_____

Gender Assigned at Birth (circle one): Male/Female

Gender Identity (circle one): Male /Female /Transgender MTF /Transgender FTM/ Decline/Other:_____

Sexual Orientation (circle one): Lesbian/Gay/ Straight/Bi-sexual / Don't Know/ Decline/Other:_____

Ethnicity (circle one): Mexican, Mexican American, or Chicano Puerto Rican Cuban
Another Hispanic, Latino/a, or Spanish Origin Not Hispanic, Latino/a, or Spanish Origin

Race: Asian Indian Chinese Filipino Japanese Korean Vietnamese Native Hawaiian Other Pacific Islander
Guamanian or Chamorro Samoan Black/African American American Indian/Alaska Native White More than one Race

Are you a migrant or seasonal farm worker? Y/N

Are you homeless (e.g. staying with others, in a hotel, in a shelter, living outside, or in a car (Y/N)

Do you require an interpreter? Y/N Are you a U.S. Veteran? Y/N

Guardian/Guarantor information (To be completed by person responsible for this account.)

Person's name responsible for this account(if other than patient listed above):_____

Relationship to patient (circle one): Parent Partner Other:_____

Address:_____City:_____State:_____Zip:_____

Date of birth of person responsible for this account:_____

FINANCIAL AGREEMENT: I hereby assign Whiteside County Community Health Clinic (WCCHC) all my rights, title and interest to reimbursement under any Medicare, Medicaid, or other insurance policies for which benefits may be available for payment of services provided. I sign as an agent, patient, or as "guarantor" that I understand my insurance company will be billed for services I receive at the WCCHC, and that I am directly responsible and agree to pay the WCCHC the balance due of all charges that may not be covered by my insurance. This may include the cost of collection and/or reasonable attorney's fees. I understand that any labs collected by the WCCHC and performed by an outside lab (LabCorp) will be billed separately to my insurance by LabCorp. I give my direct consent and express consent and permission to the clinic or business associates of the clinic to receive account communications, through various means such as 1) any cell, landline, or other phone number that I provide, 2) auto dialer systems, 3) voicemail messages, 4) text messages 5) emergency contact information, 6) pre-recorded forms of voice messaging systems. This information will not be sold.

Name:_____Signature:_____Date:_____