PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION		(0000)	(Please prin
Patient's Legal Name: (Last)	(First)		(MI)
Preferred Full Name (if different from above): _		_	
Address:			
City, State, Zip:			
Home Phone Number (landline):	Cell:	Work:	
E-Mail Address:		Date of Birt	h:
Gender Identity: Female Male Tran Additional Gender category	sgender Female to Male Transgen not listed		enderqueer Choose not to disclose
	tive Asian NativeHawaiian/Pa disclose Other not listed		rican American White
Ethnicity: Hispanic or Latino Not	Hispanic or Latino Choose not to	disclose	
	☐ ASL ☐ Japanese ☐ Mandarin☐ Arabic ☐ Vietnamese ☐ Haitian (e ☐ Tagalog ☐ Farsi-Iranian/Persiar	C <u>reo</u> le Bosni <u>an/</u> Croati	an/Ser <u>bia</u> n/Serbo-Croatian
Patient Social Security Number:			
RESPONSIBLE PARTY INFORMATION (If no		(Inform	ation used for patient balance statements
Responsible party: Another patient Gu Responsible party name: (Last) Date of birth: MM /DD /YYYY Responsible Party Social Security Number: -	(First) Sex: Female [Male	e information is same as patient (MI)
Address:			
City, State:			
INSURANCE INFORMATION: Provide your ins	surance card(s) (primary, secondary, e	etc.) to the front desk at ch	eck-in.
Emergency contact name: (Last)			
Phone number: Emergency contact relationship to patient:			you have a living will? ☐ Yes ☐ No ☐ Guardian
AddressCity, State:	ZIP:		
Home phone:		Ext.	
GENERAL CONSENT FOR CARE AND TREA	TMENT CONSENT		
TO THE PATIENT: You have the right, as a pat procedure to be used so that you may make the hazards involved. At this point in your care, no permission to perform the evaluation necessary	tient, to be informed about your condit e decision whether or not to undergo a specific treatment plan has been recor	any suggested treatment on mended. This consent for	r procedure after knowing the risks and orm is simply an effort to obtain your
This consent provides us with your permission of are indicating that (1) you intend that this consecution and (2) you consent to treatment at this office of revoked in writing. You have the right at any time.	ent is continuing in nature even after a or any other satellite office under comm	specific diagnosis has be-	en made and treatment recommended;
You have the right to discuss the treatment plar have any concerns regarding any test or treatment physician, and/or mid-level provider (nurse practice as deemed necessary, to perform reasonable a care at this practice. I understand that if additional additional consent forms prior to the test(s) or placetify that I have read and fully understand the	nent recommend by your health care p ctitioner, physician assistant, or clinica and necessary medical examination, te nal testing, invasive or interventional p procedure(s).	rovider, we encourage you I nurse specialist), and oth esting and treatment for the procedures are recommen	u to ask questions. I voluntarily request a ner health care providers or the designees e condition which has brought me to seel ded, I will be asked to read and sign
Signature of patient or personal representative:		Date:	
Printed name of patient or personal representat	tive:	Relationship to patie	ent: