Whatley Health Services, Inc.

Patient Registration/Update Form

Please Print Clearly

Last Name	First Name	Middle

Street Address	City	State	Zip Code

SSN	Date of Birth		Please Circle One:	Martial Status
		Male Female	Asian American Indian Black White Native Hawaiian Hispanic/Latino Pacific Islander More Than One Race	

Home Phone	Work Phone	Emergency Contact	Emergency Contact Phone Number, Relation to Patient	Annual Income

Please Check One: ___Hispanic *or* Non Hispanic___	Do You Need an Interpreter? ___Yes *or* No___	Do You Live in Public Housing? ___Yes *or* No___	Are You a U.S. Veteran? ___Yes *or* No___

Primary Insurance Information – Please list your insurance below

Primary Insurance			
Insurance ID Number			
Insurance Group Number			
Expiration Date			
Policy Holder (Whose Insurance)		SSN	Spouse Child Self

Secondary Insurance Information – Please list other insurance coverage below

Secondary Insurance	
Insurance ID Number	
Insurance Group Number	
Expiration Date	
Policy Holder (Who's Insurance)	

Income Information – Please complete to qualify for discounts on service

Name of Employer		
Employer Address		
Telephone Number		Salary or Rate of Pay

If not employed, please state how you support yourself: (check all that apply)

Unemployment Compensation		Amount	$
Child Support		Amount	$
AFDC		Amount	$
Social Security Benefits		Amount	$
Other		Amount	$

Household Information

Please list the names of each person in your household and amount of income received.

Name		Relation		Income	$
Name		Relation		Income	$
Name		Relation		Income	$
Name		Relation		Income	$

THERE IS A $20.00 MINIMUM FEE DUE AT TIME OF CHECK IN.

YOU WILL BE BILLED FOR THE REMAINING BALANCE OF YOUR VISIT.

TO QUALIFY FOR A DISCOUNT, PLEASE PROVIDE VERIFICATION OF INCOME.

Whatley Health Services, Inc.

Treatment, Consent and Release of Information
Financial Responsibility

I, the undersigned, hereby authorize the professional staff at Whatley Health Services, in accordance with the policies of Whatley Health Services, to render routine, diagnostic procedures, general medical treatment and/or make referrals as deemed necessary for my medical care.

Whatley Health Services, Inc. is further authorized to furnish professional information in accordance with it policies, as may be necessary for the completion of claims submitted to my insurance carrier or other Federal and/or State agencies from the medical records compiled during my office visits and are hereby released from all liability that may arise from the release of such information.

I irrevocably assign Whatley Health Services, Inc. all payments for medical services rendered. I understand that I am responsible for all charges whether or not covered by my insurance carrier or any other entity or program. If the responsible party is someone other than me, I hereby consent to Whatley Health Services, Inc. disclosing to the responsible party my personal health information.

This consent authorization applies to the initial and all subsequent visits, unless revoked by me in writing.

Certification: I certify that the information I have provided is correct to the best of my knowledge.

____

Patient Name **Date**

____

Responsible Party/Relationship to Patient **Date**

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