Patient Information (PLEASE PRINT)

PATIENT'S PREFERRED NAME: _____**Legal Name**:_____

Date of Birth: _____ Preferred Pronoun: He She They Other_____

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

Address :_____ Apt#:____ City:_____ State:_____ Zip:_____

Emergency Contact Info

Name:_____ Relationship:_____Phone #:_____

Is this visit regarding a work related injury? Y/N (i.e. injury that occurred at work)
Is this visit regarding a personal injury case? Y/N (i.e. car accident w/ third party ins)

Relationship Status (circle one): Single/Partner /Married /Divorced /Separated /Widowed /Child

Payor Source (circle all that apply): Medicare /Medicare Replacement /Medicaid /Private Ins. /Self -Pay

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:_____

Required Federal Data:

Ethnicity (circle one): Hispanic or Latino /Non-Hispanic

Race: White Black/African American Asian/Hawaiian Pacific Islander American Indian/Alaska Native More than one race

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

Do you live in homeless shelter or are you homeless? Y/N

Do you have a Developmental Disability? Y/N (like autism, cerebral palsy, epilepsy, deafness, blindness, intellectual disability, down syndrome)

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

Household Income: _____ Annually/Monthly Family Size:_____

Employment Status(circle one): Full-time Part-time Unemployed Retired Full-time Student Part-time Student Other:_____

Do you see any other providers? (i.e. specialist, other primary care)_____

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 all my rights, title and interest to medical 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 am directly responsible and agree to pay Whiteside County Community Health Clinic the balance due of all charges. This may include the cost of collection and/or reasonable attorney's fees. I assign payment of insurance benefits for services provided at Whiteside County Community Health Clinic that will be billed separately 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) emergency contact information, 5) pre-recorded forms of voice messaging systems. This information will not be sold.

Name:_____Signature:_____Date:_____