UNIVERSITY of WESTERN STATES Health Centers

NEW PATIENT REGISTRATION

Patient Information

Full Legal Name: _____

Preferred Name: _____

Social Security # _____ Date of Birth _____

Legal Sex: ☐ Female ☐ Male ☐ X ☐ Nonbinary ☐ Choose Not to Disclose

Gender Identity: ☐ Female ☐ Male ☐ Trans F to M ☐ Trans M to F ☐ Non-binary ☐ Questioning ☐ Other ☐ Choose Not to Disclose

Pronoun(s): ☐ she/her/hers ☐ he/him/his ☐ they/them/their ☐ ze/hir/hirs ☐ ey/em/eirs ☐ xe/xem/xyrs ☐ ve/vir/vis ☐ patient's name ☐ decline to answer

Street Address _____

City _____ State _____ Zip _____

Billing Address _____ ☐ Same as Street

City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ ☐ Same as Home

Work _____

Email Address _____

Communication Preference: ☐ No Preference ☐ Do Not Contact ☐ Mail ☐ Phone ☐ Email ☐ MyChart

Text Messages OK? ☐ Yes ☐ No (please provide a mobile number above to receive text messages)

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race (check all that apply): ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unknown ☐ Choose Not to disclose

Primary Language (if not English) _____ Written _____

Do you need an interpreter? ☐ Yes ☐ No _____

Emergency Contact Information

Emergency Contact _____ Relationship _____

Emergency Phone (Home) _____ (Work) _____

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Employment Background

Are you currently employed? ☐ Yes ☐ No Employment Status: ☐ Full Time ☐ Part Time ☐ Student

Current Employer _____ Employment Date _____

Street Address _____

City, State, Zip _____

Phone _____

Are you a Veteran of the US Armed Services? ☐ Yes ☐ No

Guarantor Account Information (Responsible Party for Payment)

Name _____ Social Security # _____ Date of Birth _____

Legal Sex: ☐ Female ☐ Male ☐ X ☐ Nonbinary ☐ Choose Not to Disclose

Relationship to Patient _____ ☐ Self

Address _____ ☐ Same as Patient

City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ ☐ Same as Home

Work _____

Insurance Coverage Information (Please provide your insurance card to the front desk)

Insurance Provider Name _____

Subscriber Name _____

Legal Sex: ☐ Female ☐ Male ☐ X ☐ Nonbinary ☐ Choose Not to Disclose

Subscriber Relationship to Patient _____ ☐ Self

Member # _____ Group # _____

By signing this application, I affirm under penalty that I have given true and complete information.

_____ _____

Patient Signature Date

_____ _____

Guarantor Signature Relationship to Patient