

# 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	Male    Female	Please Circle One: Asian    American Indian    Black White Native Hawaiian    Hispanic/Latino Pacific Islander    More Than One Race	Marital Status
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__
<b>Primary Insurance Information – Please list your insurance below</b>				
Primary Insurance				
Insurance ID Number				
Insurance Group Number				
Expiration Date				
Policy Holder (Whose Insurance)		SSN	Spouse	Child    Self
<b>Secondary Insurance Information – Please list other insurance coverage below</b>				
Secondary Insurance				
Insurance ID Number				
Insurance Group Number				
Expiration Date				
Policy Holder (Who's Insurance)				
<b>Income Information – Please complete to qualify for discounts on service</b>				
Name of Employer				
Employer Address				
Telephone Number		Salary or Rate of Pay		
<b>If not employed, please state how you support yourself: (check all that apply)</b>				
Unemployment Compensation		Amount	\$	
Child Support		Amount	\$	
AFDC		Amount	\$	
Social Security Benefits		Amount	\$	
Other		Amount	\$	
<b>Household Information</b>				
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 its 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.

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**Patient Name** **Date**

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**Responsible Party/Relationship to Patient** **Date**

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