Northwest Health
WellPorte

PATIENT REGISTRATION FORM (Please provide picture ID and insurance card)

Today's Date: _____/_____/_____ Primary Doctor: _____

PATIENT INFORMATION

Circle: Mr Mrs Miss Ms Marital Status (circle): Single Married Divorced Separated Widowed

Patient's Last Name: _____ First: _____ MI: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: Male Female

Social Security #: _____-_____-_____ Best # to reach you (circle): Cell Home Work

Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Email: _____

Employer: _____ Dept: _____

ALLERGIES: _____

Other Insured Family Members: _____

INSURED EMPLOYEE'S INFORMATION (only if different than above)

Employee name: _____ Date of Birth: _____/_____/___

Address: _____ City: _____

State: _____ Zip Code: _____ Social Security #: _____-_____-_____

Patient's relationship to insured employee (circle): Spouse Child Other

IN CASE OF EMERGENCY

Name: _____ Relationship to Patient: _____

Home: (____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

The above information is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____/_____/_____

Parent/Guardian Signature: _____ Date: _____/_____/_____
(if under 18)

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GENERAL CONSENT FOR TREATMENT

By signing this form, I consent that I have read, understand, and authorize the medical services provided by Northwest Health WellPorte. I am also authorizing WellPorte to bill and collect payment for the services provided. I understand that if I am not eligible for WellPorte at the time services are provided, I am responsible for paying for those services.

Patient/Parent/Guardian Signature: _____ Date: _____/_____/_____

CONFIDENTIALITY

Due to the importance of protecting the confidentiality of the patient's medical information, we will not verbally disclose any medical information to a patient's family, friend, signifcan other, or any other individual unless the patient has authorized the release of medical information by specifying in writing the list of people who may obtain such medical or private information. Whenever the patient believes the list should be changed, the patient agrees to come to the clinic and complete a new form with the updated list of individuals who may receive the patient's health or medical information.

List anyone you are authorizing to obtain verbal medical information about you. List in order of contact preference:

Name	Initiated Date	Phone #	Relationship	Discontinued Date
1				
2				
3				
4				

HOW MAY WE CONTACT YOU WITH MESSAGES/TEST RESULTS? Please indicate which you prefer:

O Leave message on machine: (_____) _____-_____ O Leave message with (name): _____

O Call at work or cell #: (_____) _____-_____ O Other (specify): _____

I do NOT want anyone other than myself given any information or contacted for any reason O Yes O No

Patient/Parent/Guardian Signature: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____