

PATIENT REGISTRATION

Patient's Legal Name: _____ (First) (Middle Initial) (Last) Last 4 Digits S.S. #: _____

Preferred Name: _____ Marital Status: _____

Due to updated Federal guidelines, we are required to obtain specific patient information. Please make sure you answer questions 1-6. Thank you.

- | | | |
|--|-------------------------------------|---|
| (1) Patient's Birthdate: _____ | (2) Patient's Age: _____ | (3) Patient's Gender: _____ |
| (4) Race (Check One) | (5) Ethnicity (Check One) | (6) Primary Language (Please List) |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> White | <input type="checkbox"/> English |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other Race | <input type="checkbox"/> _____ |
| <input type="checkbox"/> African American | <input type="checkbox"/> Declined | <input type="checkbox"/> Declined |

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell#: _____

Email: _____ Occupation: _____

Employer Name & Address: _____

SPOUSE OR SIGNIFICANT OTHER INFORMATION

Name: _____ (First) (Middle Initial) (Last) DOB: _____ Last 4 Digits S.S. #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Occupation: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell #: _____

PHYSICIAN INFORMATION

Referring Provider: _____ Phone #: _____

Primary Care Provider (If Different): _____ Phone #: _____

Other: _____ Phone #: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone #: _____
Preferred Mail Order Pharmacy: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____
Birthdate: _____
Subscriber's Name: _____
Policy/ID # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Customer Service Phone #: _____ Relationship to Patient: _____

Secondary Insurance (If Applicable): _____ Effective Date: _____
Birthdate: _____
Subscriber's Name: _____
Policy/ID # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Customer Service Phone #: _____ Relationship to Patient: _____

Tertiary Insurance (If Applicable): _____ Effective Date: _____
Birthdate: _____
Subscriber's Name: _____
Policy / ID # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Customer Service Phone #: _____ Relationship to Patient: _____

Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Clinic Administrator and Privacy Officer at 509-332-6139.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information. **By my signature below, I acknowledge receipt of Notice of Privacy Practices.**

Patient or legally authorized individual signature Date

Printed name if signed on behalf of the patient Relationship (parent, legal guardian)

Patient's Name: _____

Date of Birth: _____

CONSENT FOR ELECTRONIC COMMUNICATIONS

E-mail, Text or Other Electronic Communications. To provide the best care possible, Pullman Regional Hospital Clinic Network, LLC and its affiliates seek to communicate with its patients in a convenient and effective manner, including e-mail, text or other electronic means if requested by the patient and deemed appropriate by Pullman Regional Hospital Clinic Network, LLC. Please note that such communications sent through the internet or over phone systems may not be encrypted or secure, and could result in unauthorized persons accessing your information. If you would like Pullman Regional Hospital Clinic Network, LLC to communicate with you electronically despite these concerns, please indicate your preferred method of communication and sign below.

E-mail. Use this e-mail address: _____

Text. Use this text number: (_____) _____ - _____

Other Means (subject to Pullman Regional Hospital Clinic Network, LLC's approval):

Patient or legally authorized individual signature: _____