UNIVERSITY OF WYOMING

Albany Community Health Clinic
920 E. Sheridan St., Suite A
Laramie, WY 82070-3868
(307) 460 - 9039
Email: achc@uwyo.edu

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name (Legal)	First Name	M.I.	Date of Birth	Sex M F

Patient Mailing Address	City	State	Zip Code

Patient Physical Address (if different than Mailing Address)	City	State	Zip Code

Home Phone	Cell Phone	Email Address	Social Security #

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Student Status ☐ Full-Time ☐ Part-Time ☐ Not a Student

Employer Name	Employer Phone	Employment status ☐ Full-Time ☐ Part-Time ☐ Unemployed

Employer Mailing Address	City	State	Zip Code

HEAD OF HOUSEHOLD INFORMATION (Responsible party for account if different from above)

Last Name (Legal)	First Name	M.I.	Date of Birth	Relation to Patient

Mailing Address	City	State	Zip Code

Home Phone	Cell Phone	Email Address	Social Security #

Employer Name	Employer Phone

Employer Mailing Address	City	State	Zip Code

ETHNICITY INFORMATION

Are you Hispanic or Latino? Y N

Race

☐ White / Caucasian ☐ Other Pacific Islander ☐ Asian

☐ Native Hawaiian ☐ Alaskan Native ☐ Unreported / Refused

☐ American / Indian ☐ Black / African American

Preferred Language

INCOME INFORMATION

Would you like to apply for the Slliding Fee Discount? (if yes, we need proof of income) Y N	Family Income (Estimate)	Family Size	☐ Refuse ☐ None

REFERRAL INFORMATION

Referral Source ☐ Hospital / Clinic ☐ Phone Book ☐ Word of Mouth ☐ Radio ☐ Online ☐ Facebook ☐ Employee ☐ Newspaper ☐ TV ☐ Patient

ADDITIONAL INFORMATION

Are you: ☐ Seasonal/Agricultural Worker ☐ Migratory Worker ☐ Military Vetran ☐ Homeless, If so, where do you live?

☐ Shelter ☐ Street ☐ Relative ☐ Transitonal ☐ On Public Housing? (Excluding section 8)

EMERGENCY CONTACT INFORMATION (Not living in same household)

Last Name (Legal)	First Name	Relation to Patient	Phone

PRIMARY INSURANCE INFORMATION (We require a copy of the insurance card to file insurance)				
Insurance Name	Insured Subscriber Name			
Insured SSN / ID #	Insured D.O.B.		Effective Policy Date	
Insurance Mailing Address	City	State	Zip Code	Phone
Insured Employer Mailing Address	City	State	Zip Code	Phone

SECONDARY INSURANCE INFORMATION (We require a copy of the insurance card to file insurance)				
Insurance Name	Insured Subscriber Name			
Insured SSN / ID #	Insured D.O.B.		Effective Policy Date	
Insurance Mailing Address	City	State	Zip Code	Phone
Insured Employer Mailing Address	City	State	Zip Code	Phone

My initials state that I agree to the following:

- ☐ Treat staff and clients of UWFM with dignity and respect.
- ☐ Arrive to your appointment ten minutes early.
- ☐ Cancel appoinntment at least 24 hours before, or it will be considered a "No Show". Repeat "No Shows" which result in losing privilege to schedule future appointments.
- ☐ Payment is expected at the time of service.

AUTHORIZATION AND ASSIGNMENT

The information given on this form is true to the best of my knowledge.

Treatment/Payment Agreement for the Albany Community Health Clinic

I request the above to provide me and/or my family with medical care. I accept responsibility to pay for this care according to the fees established. Futhermore, I authorize assignment of benefits for medical service to be paid to ACHC. Also, I authorize ACHC to bill my insurance by electronic filing through a billing agency and to release any medical information needed for processing claims.

If a minor, please list any individuals able to bring child without parent / guardian present. Individual must bring valid photo ID.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ Date _____

Print Name _____ Date _____