



Albany Community Health Clinic | (307) 766-3313  
1174 N 22nd Street | Laramie, WY 82072

Wyoming Family Practice | (307) 234-6161  
1522 E. A St. | Casper, WY 82601

UW Family Medicine | (307) 632-2434  
820 E. 17th St. | Cheyenne, WY 82001

PATIENT INFORMATION					
Patient Legal Last Name		Legal First Name		M.I. Name Used	Pronoun
Date of Birth / /	Marital Status (Circle One) S / M / W / D	Mailing Address			City / State / Zip Code
Physical Address			City / State / Zip Code	Home Phone	Cell Phone
Email - provides access to Patient Portal		What is your preferred method of contact (Circle One) Cell Phone / Home Phone / Work Phone / Letter / Patient Portal			
Legal Sex at Birth Male / Female	Social Security # / /	Preferred Language		Latino or Hispanic (Circle One) Yes / No	
<b>Sexual Orientation (Circle One)</b> Straight (Not Lesbian or Gay) Lesbian or Gay Bisexual Something Else / Do Not Know Choose Not To disclose		<b>Preferred Gender Identity (Circle One)</b> Male Female Transgender Male / Female to Male Transgender Female / Male to Female Other Choose Not To Disclose		<b>Which Race do you identify with (Circle One)</b> White / Black-African American / Asian / Native Hawaiian / Other Pacific Islanders / American Indian-Alaska Native / Unreported- Refused	
How did you hear about us? (Circle One) Patient / Physician / Hospital / Friend or Family Member / Radio / TV / Yellow Pages / Website / Newspaper / Other Agency					
EMPLOYMENT / SCHOOL / HOUSING					
Employment (Circle One) FT / PT / Retired / Disabled / Not Employed		Employer	Phone	Student Status (Circle One) FT / PT	
Are you a Military Veteran (Circle One) Yes/No			Are you an Agricultural Worker (Circle One) Yes/No		
What are your current living arrangements (Circle One) Own / Rent / Living w Relatives / Shelter / Street / Other			Pharmacy Preference - Name		
INCOME INFORMATION					
What is your household income? (Circle One)			How many people live in your household? _____		
Less than \$10,000	\$30,000-\$49,999	Discounts on our fees are available based on your income and family size. Would you like to apply? (Circle One) Yes No			
\$10,000-\$14,999	\$50,000-\$79,999				
\$15,000-\$19,999	\$80,000-\$99,999				
\$20,000-\$29,999	\$100,000 +				
EMERGENCY CONTACT (For emergencies only; different from contact listed on HIPAA Form)					
Name		Relationship		Phone	
HEAD OF FAMILY - Person who is financially responsible for family members (Only if different than patient)					
Legal Last Name		Legal First Name		M.I.	Date of Birth
Mailing Address			City / State / Zip Code	Physical Address	
City / State / Zip Code		City / State / Zip Code			
Cell Phone	Home Phone	Relationship to Patient			
Legal Sex at Birth (Circle One) Male / Female	Social Security # / /		Marital Status (Circle One) S / M / W / D		
Employment (Circle One) FT / PT / Retired / Disabled / Not Employed	Employer Name		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 with dignity and respect.
- \_\_\_\_\_ Arrive to your appointment 20 minutes early. (30 minutes if you need to update insurance or re-qualify for slide). All must be completed before appointment time or you may be rescheduled or not receive the slide for that visit.
- \_\_\_\_\_ Cancel appointment at least 24 hours before, or it will be considered a "No Show." Repeat "No Shows" can result in restrictions when scheduling future appointments.
- \_\_\_\_\_ Payment is expected at the time of service.
- \_\_\_\_\_ Each clinic has the right to remove any patient or visitor at its discretion from any clinic or office area if the patient or visitor abuses any employee physically or VERBALLY.

If patient is a minor, please list parents/guardians:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_

If patient is 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 \_\_\_\_\_

**AUTHORIZATION AND ASSIGNMENT**

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

**Treatment/Payment Agreement**

I request the EHCW to provide me/my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical service to be paid to the EHCW. Also, I authorize the EHCW to bill my insurance by electronic filing through a billing agency and to release any information needed for claims processing. In the event an X-ray and/or Lab test(s) are performed during my visit, I authorize the EHCW to release information to the external agency for the purpose related to the processing and billing of the ordered film(s) and/or test(s).

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_