Albany Community Health Clinic | (307) 766-3313

2710 Harney Street, Suite 202 | Laramie, WY 82072

EHCW
EDUCATIONAL HEALTH CENTER OF WYOMING

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

IDENTIFICATION / CONTACT INFORMATION

Legal Last Name	Legal First Name	First Name Used	Middle Name

Legal Sex M / F	Date of Birth	Social Security Number / /

Mailing Address	City / State / Zip Code

Phone Number	Type Home / Mobile / Work	Consent to: ☐ Text ☐ Call

Phone Number	Type Home / Mobile / Work	Consent to: ☐ Text ☐ Call

Email Address (Provides access to Patient Portal)	Contact Preference Home Phone / Work Phone / Mobile Phone / Mail / Portal	Preferred Pharmacy

DEMOGRAPHICS

**Add disclaimer about why we collect this information*

Language English / Spanish / Arabic / Chinese / Polish / Portuguese / Russian / Somali / Vietnamese / Other: _____ Do you need a translator? Yes / No	Race American Indian / Alaska Native / Asian / Asian Indian / Black/African American / European / Filipino / Japanese / Korean / Native Hawaiian or Other Pacific Islander / White	Ethnicity Central American / Cuban / Dominican / Hispanic or Latino/Spanish / Latin American/Latino / Mexican / Not Hispanic or Latino / Puerto Rican / South American / Spainard

Marital Status Married / Single / Divorced / Separated / Widowed / Partner / Unknown	Sexual Orientation Lesbian, Gay or Homosexual / Straight or Heterosexual / Bisexual/ Don't Know / Choose Not to Disclose Something Else: _____	Gender Identity Female / Male / Transgender Male (Female to Male) / Transgender Female (Male to Female) / Gender non-conforming / Choose not to disclose Additional Category: _____

Assigned Sex at Birth M / F / Unknown / Choose not to Disclose	Pronouns She/Her / He/Him / They/Them

Number of People in Your Household	Total Household Income $

Please Circle Any of the Following that Apply to You: Agricultural Worker / Homeless / Veteran / Utilize Public Housing	Would you like to apply for our sliding fee scale? *Selecting yes does not automatically qualify you – additional paperwork is required Yes / No

ADDITIONAL INFORMATION

How Did you Hear About Us? Marketing/Advertising / Physician / Community Event / Word of Mouth / Patient / Hospital / Online/Website Other:	Patient Care Summary and Patient Letter Delivery Preference Portal / Paper

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EHCW
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EMERGENCY CONTACT

Name	Relationship Spouse / Parent / Child / Sibling / Friend / Cousin / Guardian / Other	Phone

PARENT / GUARDIAN INFORMATION

For patients under 18 or those over 18 with a legal guardian

Last Name	First Name	Relationship
Last Name	First Name	Relationship

GUARANTOR INFORMATION

Person Financially responsible for bill – Typically for patients under 18 or those over 18 with a legal guardian

Last Name	First Name	Middle Name	DOB / /
Mailing Address	City / State / Zip Code		*This is where your bill will be sent
SSN	Phone	Email	Employer

INSURANCE INFORMATION

This information helps insurance identify the correct member and process the claim appropriately

Insurance Carrier	Member ID	Group Number
Policy Holder Last Name	Policy Holder First Name	Policy Holder Address / City / State / Zip
Policy Holder SSN	Policy Holder DOB / /	Policy Holder Sex M / F	Policy Holder Employer Name

SECONDARY INSURANCE INFORMATION

Insurance Carrier	Member ID	Group Number
Policy Holder Last Name	Policy Holder First Name	Policy Holder Address / City / State / Zip
Policy Holder SSN	Policy Holder DOB / /	Policy Holder Sex M / F	Policy Holder Employer Name

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EHCW
EDUCATIONAL HEALTH CENTER OF WYOMING

My initials state that I agree to the following:

_____ Treat staff and clients with dignity and respect.

_____ Arrive to my 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.

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 _____