497 W Lott Buffalo, WY 82834

JOHNSON COUNTY HEALTHCARE CENTER / FAMILY MEDICAL CENTER PATIENT REGISTRATION FORM

**** Please make sure you provide an updated copy of your driver's license and insurance card ****

Patient Information:

Last Name: _________________________________ MI: _________ First Name: _____________________________________

Date of Birth: _____/_____/_____ SSN: _________________________ Previous Name(s): _____________________________

Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Mailing Address: _____________________________________ City: _________________ State: _____________ Zip: _________

Phone: Home: _______________________ Cell: ______________________ Work: _____________________

Employer: ____ Phone: _____________________________

Employer Address: ____

Communication Preferences: If patient is under age 18, reply with Parent/Guardian information.

Preferred method of contact: ☐ Home ☐ Cell ☐ Work

Can we leave a message regarding your medical care and test results on your preferred phone? ☐ Yes ☐ No

Would you like to receive appointment reminders? ☐ Yes ☐ No Method: ☐ Text ☐ Phone Call

Would you like to receive health information through our Patient Portal? ☐ Yes ☐ No If yes, please provide email below.

Email address: ____

In case of emergency:

Emergency Contact: ____

Emergency Contact Phone: ____________________________________ Relationship to patient: __________________________

Additional Information:

Preferred Language: ☐ English ☐ Other __________________ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ African/African American ☐ Asian/Asian American ☐ Caucasian

☐ Native American / Alaskan Native ☐ Native Hawaiian / Other Pacific Islander

Were you ever in the military? ☐ Yes ☐ No

Religion: ____________________________________

Responsible Party: If different than patient.

Last Name: _________________________________ MI: _________ First Name: _____________________________________

Date of Birth: _____/_____/_____ SSN: _________________________ Relationship: _________________________________

Gender: ☐ Male ☐ Female ☐ Other

Address: _______________________________________ City _________________ State______________ Zip _________

Phone: Home: _________________________________ Cell: _______________________________

497 W Lott Buffalo, WY 82834

JOHNSON COUNTY HEALTHCARE CENTER / FAMILY MEDICAL CENTER
PATIENT REGISTRATION FORM

Insurance Information: Please provide front desk with a copy

Primary Insurance:

Name and Address

____

____

____

Policy ID#: _________________________________

Group #: ___________________________________

Subscriber's Name:

____

Date of Birth: _____/_____/_____

SSN: _________________________

Relationship to Patient: _______________________

Secondary Insurance:

Name and Address

____

____

____

Policy ID#: _________________________________

Group #: ___________________________________

Subscriber's Name:

____

Date of Birth: _____/_____/_____

SSN: _________________________

Relationship to Patient: _______________________

Injury or Accident:

1. Is this visit related to an illness or injury due to a work-related accident or condition? ☐ No ☐ Yes

If yes, please provide the following and fill out and provide a Workman's Compensation form:

Date of injury: __________________ Employer: ___________________________________ Case Number: __________________

2. Is this visit related to an illness or injury due to an automobile accident or condition? ☐ No ☐ Yes

If yes, please provide the following:

Date of injury: __________________ Auto Insurance: _______________________________ Policy Number: _________________

Medicare Patients Only:

1. Are you entitled to Medicare based on: ☐ Age ☐ Disability ☐ End-Stage Renal Disease (ESRD)
2. Are you receiving Black Lung (BL) benefits? ☐ No ☐ Yes Date benefits began: _________________________
3. Are the services to be paid by a government program such as a research grant? ☐ No ☐ Yes
4. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? ☐ No ☐ Yes
5. Is this visit related to an illness or injury due to a non-work-related accident? ☐ No ☐ Yes

   If yes, please provide the following:

   Date of injury: __________________
6. Are you currently employed? ☐ No ☐ Yes

   If no, are you retired? ☐ No ☐ Yes - Date of retirement: __________________

   If yes, do you have group health plan coverage based on your current employment? ☐ No ☐ Yes
7. Is your spouse currently employed? ☐ No ☐ Yes ☐N/A

   If no, are you retired? ☐ No ☐ Yes - Date of retirement: __________________

   If yes, do you have group health plan coverage based on your spouse's current employment? ☐ No ☐ Yes
8. Are you covered under a group health plan of a family member other than your spouse? ☐ No ☐ Yes