Sound Health Care CENTER

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Patient Registration

NAME:	**DATE OF BIRTH:**	**SSN:**
ADDRESS:		
PHONE:	**PHONE #2:**	
EMAIL:		
MARITAL STATUS: M S D W	**LEGAL SEX:** M F Other	**IDENTIFIES AS:** M F Other:
EMPLOYMENT STATUS:	**PLACE OF EMPLOYMENT/SCHOOL:**	
RACE/ETHNICITY (please circle): American Indian/Alaskan Native; Black or African American; Native Hawaiian or Other Pacific Islander; Asian; Hispanic or Latino(a); White; Other (please list) **LANGUAGE:**		

Patient Insurance Information

RESPONSIBLE PARTY:	**RELATIONSHIP:**	**DOB:**
ADDRESS OF RESPONSIBLE PARTY:		
INSURANCE COMPANY:	**INSURANCE PHONE:**	
INSURANCE CLAIMS ADDRESS:		
POLICY HOLDER:	**RELATIONSHIP:**	**DATE OF BIRTH:**
MEMBER ID:	**GROUP NO:**	

Patient Preferences

EMERGENCY CONTACT:	**PHONE:**	**RELATIONSHIP:**
PREFERRED PHARMACY:	**PREFERRED IMAGING FACILITY:**	
ARE YOU INTERESTED IN PARTICIPATING WITHIN MEDICAL RESEARCH STUDIES: YES or **NO**		
HOW DID YOU HEAR ABOUT US:		

MEDICAID RELEASE

By initialing, I verify that I am not receiving DSHS Medical Assistance and I agree to pay for services rendered. If I later become eligible for DSHS Medical Assistance, I agree to notify Sound Health Care Center as soon as I become eligible. _____(initials)

RELEASE OF BENEFITS AND INFORMATION

I consent for medical treatment and have verified the information listed on this slip and authorize my insurance benefits be paid directly to Sound Health Care Center. I am financially responsible for any balance due and understand that all charges are due and payable within 30 days following the date

SURESCRIPTS RELEASE OF INFORMATION

SHCC (Sound Health Care Center) uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to SHCC. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

WAIIS RELEASE

SHCC participates in The Washington State Immunization Information System (WAIIS), a lifetime registry that tracks immunization records for people of all ages. By signing below you are authorizing Sound Health Care Center to release your vaccination history to the WAIIS to keep your vaccination records up to date with live data. This authorization can be revoked at any time by notifying SHCC via written communication. Additional forms may be required.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative — Date

_____ _____

Printed name of Authorized Representative — Relationship to patient