

New Patient Registration

795 E. Second Street, Suite 2 Pomona, CA 91766-2007 Tel: (909) 706-3899 8686 Haven Avenue, Suite 200 Rancho Cucamonga, CA 91730-9110 Tel: (909) 706-3950

PATIENT INFORMATION (PLEASE PRESS DOWN FIRMLY W	HEN PRINTING	CLEARLY):	Date:	, 20
Name				
Last	First		Mic	ddle Initial
Street Address	DOB	Age	Marital Status	s: SMWD
City / State / Zip Code		M / F	Occupation	
Cell # () Work # () _			Home # ()	
Email		SSN # (last 4 digits	s)	
Which would you prefer for notices (circle one):	nail /	US Mail	,	
Employer Name	Title		Work#(.)
Work Address				,
Street Address Apt / Spa	ce #	City	State Zip C	 Code
Emergency Contact Person:			Phone Number:	
Spouse / Parent / Guardian Name:				
Cell Phone:		Other Phone: ()	
(if spouse - a phone number other than home)		number(s) listed can be us	sed to contact you for other than r	nedical purposes
INCOMPLETE INSURANCE INFOR	RMATION MAY	RESULT IN CLAIM DEI	<u>VIAL BY THE PAYER!</u>	
PRIMARY MEDICAL INSURANCE COMPANY:			DICAL INSURANCE COMPAN	IY:
Responsible Party for		Responsible Party	1	
Payment:		for Payment:		
RELATIONSHIP:		RELATIONSHIP:		
ID / POLICY NUMBER:		ID / POLICY NUME		
GROUP NUMBER:		GROUP NUMBER:		
NAME OF SUBSCRIBER / INSURED:		NAME OF SUBSCR	RIBER / INSUR <u>ED:</u>	
DATE OF BIRTH: SOCIAL SECURITY NUMBER:		DATE OF BIRTH: SOCIAL SECURITY	NI IMPED.	-
ENADLOVED NAME.		EMPLOYER NAME		
PHONE NO: ()			:)	
Who is your Primary Care doctor?			- /	
Address/Phone number for Primary Care doctor:				
Primary Language:			ed:YesNo)
Do you have an Advance Healthcare Directive?Ye	<u>.</u>			y.)
Would you like information regarding Advance Healthcare	Directive?	Yes	No	
Responsible Party: Please remember that insurance is cons				doctor and is not a
substitute for payment. Some companies pay fixed allowar			·	
to pay any deductible amount, co-insurance, or any other	-		-	your responsioner,
CONSENT AND ASSIGNMENT:		, ,		
Little Consents Tool Though and a death		et e este e fille dib fet		
Initial - Consent to Treat: I hereby request and author		•	-	
medical/surgical care, tests, procedures, drugs and other so	•	'	•	•
well-being. It is understood that this consent is given in ad				
Health Sciences may exercise their best judgment as to pro	iper medicai car	e, willcii may be fiece	essary to protect my me and	a neditii.
Initial - Assignment of Benefits: I hereby assign direct	tly to the Weste	ern University of Heal	th Sciences all surgical and/	or medical benefits
if any, otherwise payable to me for services rendered. I un				
insurance.			-	
Signature:		DA	TE:	
(IF THE PATIENT IS A MINOR SIGNA	TURE OF DAREN	IT OR GHARDIAN ALIT	HORIZING TREATMENTS)	

PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO THE RECEPTIONIST

NOTE: Please notify us if any of the above information changes during the course of your treatment.



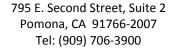
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INSTRUCTIONS ON HOW TO CONTACT PATIENT

Patient Name:	Date of Birth:		
One of our goals is to protect your rights to privacy; the will not be given to anyone regarding you or your finan			nation
May we call you at work?		Yes	No
That is call you at the the			
May we call you at home?			
If no to both questions above, do you have an alternation to to both questions above, do you have an alternation to both questions above.	tive number, e.g., cell phone	e we can	
If yes, what is that number? May we leave messages (including appointment inform	mation) on your answering		
machine/voice mail?			
May we send you a fax?			
If so, what is the phone number?			
May we send you an email?			
If so, what email address should we use?			
We will only provide information about you to those lis Name:	ted below: Phone:		
Name:	Phone:		
Name:	Phone:		
Patient/Guarantor Signature	 		_

Note: this consent is valid until otherwise notified in writing.

Note: a photocopy or electronic scan of this document shall be as valid as an original





AUTHORIZATION FOR PHOTOGRAPHY OF PATIENT

The undersigned patient, legal guardian or conservator, agrees that Western University of Health Sciences, Patient Care Center (the Center) may photograph me/the patient for the purposes of documenting my progress related to my health. My signature below indicates that I understand that:

- Photographs may be recorded to document my current care and treatment, and/or to document the progress of said treatment.
- The same statutory rules of patient privacy rights to confidentiality apply to any photographs taken by the Center.
- The Center will retain the ownership rights to these photographs, but that I will be allowed access to view them or obtain photocopies.
- These images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law.
- The images can be used without personal identifiers for teaching, academic / scientific
 presentations, professional portfolios and purposes not related to advertising or other
 commercial interests e.g., examples of surgical procedures or dental care provided by
 the student dentist for job interviews.
- The parts of my body that may be photographed are:

Date	Print Name
Signature of Patier	nt/Legal Representative/Conservator Sign
Relationship	

Note: a photocopy or electronic scan of this document shall be as valid as an original



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

DATE:	, 20	·			
Sciences' Notice of	(WesternU) Patien	nt Care Center	Notice of Priva	y of Western University of of Western University of one of the contraction of the contract of	d that the
Pa	atient Name (Print)		Patient Sig	nature	
	m is completed by o	a patient's leg	al representat	ive, please print and sign	your name
Le	egal Representative	Print)	Legal Repr	esentative's Signature	
			Relationsh	ip	
	Thi	s Section to be	e Completed by	y WesternU:	
Complete	this section if this form	า is not signed an	d dated by the po	ntient or patient's personal rep	resentative.
	de a good faith effort actices but was unabl		_	ment of receipt of WesternU'	s Notice of
	□ Patient refused□ Patient unable□ Other	_			
Employee	Name (Print)	Employee Si	gnature	Date	
	This form	must be place	d in the patien	t's medical record.	