WesternU Health

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 WHEN PRINTING CLEARLY): Date: _____, 20 _____

Name _____
Last First Middle Initial

Street Address _____ DOB _____ Age _____ Marital Status: S M W D

City / State / Zip Code _____ M / F Occupation _____

Cell # (____) _____ Work # (_____) _____ Home # (_____) _____

Email _____ SSN # (last 4 digits)_____

Which would you prefer for notices (circle one): Email / US Mail

Employer Name _____ Title _____ Work # (____) _____

Work Address _____
Street Address Apt / Space # City State Zip Code

Emergency Contact Person:_____ Phone Number: _____

Spouse / Parent / Guardian Name: _____ Relationship: _____

Cell Phone: _____ Other Phone: (_____)
(if spouse - a phone number other than home) The phone number(s) listed can be used to contact you for other than medical purposes

INCOMPLETE INSURANCE INFORMATION MAY RESULT IN CLAIM DENIAL BY THE PAYER!

PRIMARY MEDICAL INSURANCE COMPANY:

Responsible Party for Payment: _____
RELATIONSHIP: _____
ID / POLICY NUMBER: _____
GROUP NUMBER: _____
NAME OF SUBSCRIBER / INSURED: _____
DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____
EMPLOYER NAME: _____
PHONE NO: (_____) _____

SECONDARY MEDICAL INSURANCE COMPANY:

Responsible Party for Payment: _____
RELATIONSHIP: _____
ID / POLICY NUMBER: _____
GROUP NUMBER: _____
NAME OF SUBSCRIBER / INSURED: _____
DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____
EMPLOYER NAME: _____
PHONE NO: (_____) _____

Who is your Primary Care doctor? _____

Address/Phone number for Primary Care doctor: _____

Primary Language: _____ Interpreter Service Required: _____Yes _____No

Do you have an Advance Healthcare Directive? _____Yes _____No **(If yes, please provide our office with a copy.)**

Would you like information regarding Advance Healthcare Directive? _____Yes _____No

Responsible Party: Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

CONSENT AND ASSIGNMENT:

_____Initial - Consent to Treat: I hereby request and authorize Western University of Health Sciences to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial for my health and well-being. It is understood that this consent is given in advance of any specific service, but is given in order that Western University of Health Sciences may exercise their best judgment as to proper medical care, which may be necessary to protect my life and health.

_____Initial - Assignment of Benefits: I hereby assign directly to the Western University of Health Sciences all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ DATE: _____

(IF THE PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING 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.

Est. 5-10; Rev.: 4-14; 5-17

Western University of Health Sciences
Eye Care Institute

795 E. Second Street, Suite 2
Pomona, CA 91766-2007
Tel: (909) 706-3900

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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; therefore, unless we have your permission, information will not be given to anyone regarding you or your finances.

	Yes	No
May we call you at work?		
May we call you at home?		
If no to both questions above, do you have an alternative number, e.g., cell phone we can contact you at? If yes, what is that number?		
May we leave messages (including appointment information) 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 listed below:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

_____ _____

Patient/Guarantor Signature Date

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

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Western University of Health Sciences
Eye Care Institute

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 Patient/Legal Representative/Conservator Signature

_____
Relationship

_____ _____
Date Witness Signature

_____
Witness's Printed Name

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 _____

By signing this form, I acknowledge that I received a copy of Western University of Health Sciences' (WesternU) Patient Care Center Notice of Privacy Practices. I understand that the Notice of Privacy Practices provides information about how WesternU may use and disclose my health information.

_____ _____
Patient Name (Print) Patient Signature

If this form is completed by a patient's legal representative, please print and sign your name in the space below:

_____ _____
Legal Representative (Print) Legal Representative's Signature

_____
Relationship

This Section to be Completed by WesternU:

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of WesternU's Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign
□ Patient unable to sign
□ Other _____

_____ _____ _____
Employee Name (Print) Employee Signature Date

This form must be placed in the patient's medical record.