WesternU Health | Pomona

New Patient Registration

795 E. Second Street | Pomona, CA 91766-2007 | Tel: (909) 706-3900
Eye Care Institute, Ste. 2 | Medical Center, Ste. 5 | Podiatry, Ste. 7

Date: _____ / _____ / __________

Name: ____
Last First Middle Initial

Street Address: ______________________ DOB: __________ Age: ________ Marital Status: **S M W D**

City / State / Zip Code: ______________________________ M / F Occupation: ____________________

Cell # (____) ____________________ Home # (____) ____________________ Work # (____) ____________________

Email: ______________________________ SSN # (last 4 digits): ______________________

Preference for Communications (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 # **(____)** ____________________ Other # **(____)** ____________________ The phone number(s) listed can be used to contact you for additional purposes

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

PRIMARY MEDICAL INSURANCE COMPANY:

Name of Main Subscriber: ______________________________
Relationship: ______________________________
ID / Policy Number: ______________________________
Group Number: ______________________________
Main Subscriber Date of Birth: ______________________________
Last 4 Digits of SSN: ______________________________
Employer Name: ______________________________

SECONDARY MEDICAL INSURANCE COMPANY:

Name of Main Subscriber: ______________________________
Relationship: ______________________________
ID / Policy Number: ______________________________
Group Number: ______________________________
Main Subscriber Date of Birth: ______________________________
Last 4 Digits of SSN: ______________________________
Employer Name: ______________________________

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? ________ Y ________ N

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 WesternU Health 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 WesternU Health 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 WesternU Health 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 A PARENT OR GUARDIAN IS NEEDED FOR 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.

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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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AUTHORIZATION FOR PHOTOGRAPHY OF PATIENT

The undersigned patient, legal guardian or conservator, agrees that WesternU Health, 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 WesternU Health's (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 Signature Employee Name Date

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