EHCW
Educational Health Center of Wyoming

Albany Community Health Clinic | (307) 766-3313
1174 N 22nd Street | Laramie, WY 82072

UW Family Practice | (307) 234-6161
1522 E. A St. | Casper, WY 82601

UW Family Medicine | (307) 632-2434
820 E. 17th St. | Cheyenne, WY 82001

PATIENT INFORMATION

Patient (Legal) Last Name	First Name	M.I.	Preferred Name

Date of Birth / /	Marital Status (Circle One) S / M / W / D	Mailing Address City / State / Zip Code

Physical Address City / State / Zip Code	Home Phone	Cell Phone

Email - provides access to Patient Portal	What is your preferred method of contact (Circle One) Cell Phone / Home Phone / Work Phone / Letter / Patient Portal

Sex At Birth Male / Female	Social Security # / /	Preferred Language	Latino or Hispanic (Circle One) Yes / No

Sexual Orientation (Circle One)	**Gender Identity (Circle One)**	**Which Race do you identify with (Circle One)**
Straight (Not Lesbian or Gay) Lesbian or Gay Bisexual Something Else / Do Not Know Choose Not To disclose	Male Female Transgender Male / Female to Male Transgender Female / Male to Female Other Choose Not To Disclose	White / Black-African American / Asian / Native Hawaiian / Other Pacific Islanders / American Indian-Alaska Native / Unreported-Refused

How did you hear about us? (Circle One) Patient / Physician / Hospital / Friend or Family Member / Radio / TV / Yellow Pages / Website / Newspaper / Other Agency

EMPLOYMENT / SCHOOL / HOUSING

Employment (Circle One) FT / PT / Retired / Disabled / Not Employed	Employer Phone	Student Status (Circle One) FT / PT

Are you a Military Veteran (Circle One) Yes/No	Are you an Agricultural Worker (Circle One) Yes/No

What are your current living arrangements (Circle One) Own / Rent / Living w Relatives / Shelter / Street / Other	Pharmacy Preference - Name

INCOME INFORMATION

What is your household income? (Circle One)	
Less than $10,000 $30,000-$49,999 $10,000-$14,999 $50,000-$79,999 $15,000-$19,999 $80,000-$99,999 $20,000-$29,999 $100,000 +	**How many people live in your household?_____** **Discounts on our fees are available based on your income and family size. Would you like to apply? (Circle One) Yes No**

EMERGENCY CONTACT (For emergencies only; different from contact listed on HIPAA Form)

Name	Relationship	Phone

HEAD OF FAMILY - Person who is financially responsible for family members (Only if different than patient)

(Legal) Last Name	First Name	M.I.	Date of Birth

Mailing Address City / State / Zip Code	Physical Address City / State / Zip Code

Cell Phone	Home Phone	Relationship to Patient

Sex (Circle One) Male / Female	Social Security # / /	Marital Status (Circle One) S / M / W / D

Employment (Circle One) FT / PT / Retired / Disabled / Not Employed	Employer Name Phone

PRIMARY INSURANCE INFORMATION (We require a copy of the insurance card to file insurance)				
Insurance name			Insured Subscriber Name	
Insured SSN / ID #	Insured D.O.B		Effective Policy Date	
Insurance Mailing Address	City	State	Zip Code	Phone
Insured Employer Mailing Address	City	State	Zip Code	Phone
SECONDARY INSURANCE INFORMATION (We require a copy of the insurance card to file insurance)				
Insurance name			Insured Subscriber Name	
Insured SSN / ID #	Insured D.O.B		Effective Policy Date	
Insurance Mailing Address	City	State	Zip Code	Phone
Insured Employer Mailing Address	City	State	Zip Code	Phone

My initials state that I agree to the following:

_____ Treat staff and clients with dignity and respect.

_____ Arrive to your appointment 20 minutes early. (30 minutes if you need to update insurance or re-qualify for slide). All must be completed before appointment time or you may be rescheduled or not receive the slide for that visit.

_____ Cancel appointment at least 24 hours before, or it will be considered a "No Show." Repeat "No Shows" can result in restrictions when scheduling future appointments.

_____ Payment is expected at the time of service.

_____ Each clinic has the right to remove any patient or visitor at its discretion from any clinic or office area if the patient or visitor abuses any employee physically or VERBALLY.

If patient is a minor, please list parents/guardians:

Name _____ Relationship _____

Name _____ Relationship _____

If patient is a minor, please list any individuals able to bring child without parent / guardian present. Individual must bring valid photo ID.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

AUTHORIZATION AND ASSIGNMENT

The information given on this form is true to the best of my knowledge.

Treatment/Payment Agreement

I request the EHCW to provide me/my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical service to be paid to the EHCW. Also, I authorize the EHCW to bill my insurance by electronic filing through a billing agency and to release any information needed for claims processing. In the event an X-ray and/or Lab test(s) are performed during my visit, I authorize the EHCW to release information to the external agency for the purpose related to the processing and billing of the ordered film(s) and/or test(s).

Signature _____ **Date** _____

Print Name _____