Patient Information

Annual Registration

Last Name________________ First Name________________ Middle Name________________

Address________________ Apt#________________

City________________ State________________ Zip________________

Birthdate________________ SSN________________ Patient / Guardian E-Mail________________@________________

Home Phone________________ Cell Phone________________ Employer________________ Work Phone________________

Preferred Communication Method: ☐ Phone ☐ Email (MyChart) ☐ US Mail

Preferred Pharmacy: ☐ Waco Family Medicine ☐ Other ________________

PREFERRED LANGUAGE
- ☐ ENGLISH
- ☐ SPANISH
- ☐ SIGNING / ASL
- ☐ OTHER

MARITAL STATUS
- ☐ SINGLE
- ☐ MARRIED
- ☐ WIDOWED
- ☐ DIVORCED

HISPANIC OR LATINO/A ETHNICITY
- ☐ NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN
- ☐ YES, MEXICAN, MEXICAN AMERICAN, CHICANO/A
- ☐ YES, PUERTO RICAN
- ☐ YES, CUBAN
- ☐ YES, ANOTHER HISPANIC, LATINO/A OR SPANISH ORIGIN

RACE MARK ALL THAT APPLY
- ☐ WHITE
- ☐ CHINESE
- ☐ FILIPINO
- ☐ JAPANESE
- ☐ KOREAN
- ☐ VIETNAMESE
- ☐ ASIAN INDIAN
- ☐ BLACK / AFRICAN AMERICAN
- ☐ OTHER ASIAN
- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ GUAMANIAN OR CHAMORRO
- ☐ SAMOAN
- ☐ NATIVE HAWIIAN
- ☐ OTHER PACIFIC ISLANDER

SEX AT BIRTH
☐ Male ☐ Female

SEXUAL ORIENTATION
- ☐ STRAIGHT (NOT LESBIAN OR GAY)
- ☐ LESBIAN
- ☐ GAY
- ☐ BISEXUAL
- ☐ SOMETHING ELSE
- ☐ DO NOT KNOW
- ☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY
- ☐ MALE
- ☐ TRANSGENDER MAN/ TRANSGENDER MALE/ TRANSMASCULINE
- ☐ FEMALE
- ☐ TRANSGENDER WOMAN/ TRANSGENDER FEMALE/ TRANSFEMININE
- ☐ OTHER
- ☐ CHOOSE NOT TO DISCLOSE

VETERAN STATUS
- ☐ ACTIVE DUTY
- ☐ DISCHARGED (VETERAN)
- ☐ NATIONAL GUARD
- ☐ RESERVES
- ☐ NONE

FARM WORKER STATUS
- ☐ MIGRATORY FARM WORKER
- ☐ SEASONAL FARM WORKER
- ☐ NOT A FARM WORKER

IN PUBLIC HOUSING
☐ YES ☐ NO

HOUSEHOLD INFORMATION

HOW MANY PEOPLE ARE IN YOUR HOUSEHOLDINCLUDING YOURSELF? ________________

WHAT IS YOUR MONTHLY HOUSEHOLD INCOME?________________
- ☐ I HAVE NO INCOME ($0)
- ☐ MY MONTHLY INCOME IS $________________
- ☐ MY YEARLY INCOME IS $________________

HOMELESS STATUS
- ☐ NOT HOMELESS
- ☐ DOUBLED UP (LIVING WITH OTHERS)
- ☐ IN A HOMELESS SHELTER
- ☐ TRANSITIONAL HOUSING
- ☐ ON THE STREET
- ☐ PERMANENT SUPPORTIVE HOUSING (THROUGH MHMR / FAMILY ABUSE CENTER)

PARENT / GUARDIAN / GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) INFORMATION

Patients under the age of 18 MUST have a Guarantor

RELATIONSHIP TO PATIENT: ☐ SELF ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER

NAME________________ BIRTHDATE________________ SSN________________

ADDRESS ☐ CHECK IF SAME AS ABOVE________________ CITY________________ STATE________________ ZIP________________

HOME PHONE________________ CELL PHONE________________ WORK PHONE________________ EMPLOYER________________

PRIMARY **MEDICAL** Insurance

INSURANCE NAME________________ Member ID #________________ GROUP #________________

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME________________

☐ MALE ☐ FEMALE BIRTHDATE________________ SSN________________ RELATIONSHIP TO PATIENT________________

ADDRESS ☐ CHECK IF SAME AS ABOVE________________ CITY________________ STATE________________ ZIP________________

PRIMARY **DENTAL** Insurance

INSURANCE NAME________________ Member ID #________________ GROUP #________________

IS THE POLICY HOLDER THE PATIENT? ☐ YES ☐ NO (IF NO, PLEASE COMPLETE THIS SECTION) POLICY HOLDER INFORMATION: NAME________________

☐ MALE ☐ FEMALE BIRTHDATE________________ SSN________________ RELATIONSHIP TO PATIENT________________

ADDRESS ☐ CHECK IF SAME AS ABOVE________________ HOME PHONE________________ CITY________________ STATE________________ ZIP________________

(Rev.01.03.2025)

Patient Information

Annual Registration

General Consent to Treat

I hereby consent to any and all treatment that my Waco Family Medicine (hereinafter "WFM") clinician and I agree is necessary for me or for the patient(s) I am guardian for.

I understand and acknowledge that WFM is a teaching center, and my care, and/or the care of patients(s) I am guardian for, at WFM may be provided by a clinician, including but not limited to medical students and/or resident physicians and/or resident dentists, in a clinical training program. I further understand and acknowledge that teaching services such as direct observation by other physicians or medical students and case discussions of care activities involving me or my dependents are allowed for teaching purposes unless specifically denied by me. I understand and acknowledge that certain clinical visits may be delivered by telehealth (video or telephone) services, during which I will not be physically in the same room as my clinician. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, my telehealth visit may be discontinued or converted into an in-person visit.

I further understand that as part of its health care services, WFM personnel and my clinician create and maintain a record of care and services provided. I understand that such information may be used and/or disclosed in the management and delivery of care and services provided by WFM, as described in the Notice of Privacy Practices. I understand and acknowledge that WFM participates in an electronic health record exchange program, and that if I seek treatment from other healthcare facilities or providers participating in this exchange program, my health information, or that of the patient(s) I am guardian for, may be shared between WFM and those other facilities or providers. I understand and acknowledge that as part of receiving my healthcare at Waco Family Medicine, WFM's clinicians and other personnel may electronically request and/or provide health records for me and/or patient(s) I am guardian for, to those participating facilities or providers. These records include, but are not limited to prescription medication history, as well as information related to mental health treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment, and/or HIV (AIDS) testing/results and/or treatment. I further understand that any such information from any source whatsoever may become part of the requesting party's health records about me and/or the patient(s) I am guardian for.

By providing my mobile phone number, I consent to text messages regarding upcoming appointments and other notifications related to my healthcare and services provided by Waco Family Medicine. I understand that there may be text or data charges from my mobile carrier.

NOTICE OF PRIVACY PRACTICES

I hereby understand that I have the right to request a copy of Waco Family Medicine's Notice of Privacy Practices.

LIMITED ENGLISH PROFICIENCY

Waco Family Medicine proudly offers language assistance to its patients free of charge. WFM also strives to make reasonable accommodations for disabled patients.

PHOTOGRAPHY AND VIDEO

I understand WFM personnel and/or my clinician may request to take photographic and/or video images for the purpose of identification and documentation of my medical care. I also understand that such images may be used for teaching purposes. I understand that I have the right to refuse to have such photographic and/or video images taken.

STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby acknowledge I am the person primarily responsible for payment of all charges for services rendered by Waco Family Medicine, regardless of any insurance coverage I might have, including Medicare or Medicaid, and that such payment is due on demand. I understand that I may be charged for multiple services provided on the same day. (For example, WFM offers integrated behavioral health services; this means that many patients are offered the opportunity to see a counselor during the same visit that they see a medical clinician. This may result in additional charges. You have the right to decline these same-day counseling services.) I understand that any payments I make that exceed the charges for an individual visit or service will be applied to any outstanding balance on my patient account and that such overpayments may not be refunded to me unless my account balance is $0. I further understand that in addition to such service charges, I will be liable for any court costs, attorney's fees, collection expense, or interest that may be incurred should such actions be required to obtain payment for services rendered by Waco Family Medicine. I certify that the patient and financial information given at the time of services rendered is accurate and complete.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of service rendered, I hereby irrevocably assign and transfer to WFM, all rights, title and interest in benefits payable for services rendered by Waco Family Medicine. I hereby authorize and instruct the insurance company and/or Financial Program to pay directly to Waco Family Medicine all benefits due under the terms of my policy or policies. I understand that my insurance policy/financial program, or their health-insuring agent(s), determine the medical necessity of services/items I request and receive. I also understand that I am responsible for payment of services or items I request and receive if these services/items are determined by my insurance policy/financial program not to be reasonable and medically necessary for my care.

OUTSIDE DIAGNOSTIC CHARGES

Laboratory testing for specimens as well as imaging services (x-rays/CT/ultrasounds) performed at Waco Family Medicine may be sent to an independent lab or radiologist and will be billed to me directly from that independent facility. There is also a lab handling fee for obtaining lab specimen(s) which is billed through Waco Family Medicine. Upon receiving a statement, I understand that I am to contact that laboratory or radiology company to arrange payment or exchange insurance information. I understand that these diagnostic charges are my financial responsibility.

PATIENT /GUARDIAN SIGNATURE

I have read and understand this document.

PATIENT SIGNATURE______________________________ DATE ____________________

PARENT/GUARDIAN* SIGNATURE______________________ RELATIONSHIP TO PATIENT ______________

PRINTED NAME____________________________________

Proof of legal guardianship (MAY) be required

Office Use Only
Processed by:

(Rev.01.03.2025)