PATIENT'S NAME _____ **DATE OF BIRTH** _____

Gender
__ Male
__ Female
__ Trans MTF
__ Trans FTM
__ Nonbinary/Genderqueer
__ Other: _____
__ Choose not to disclose

Sex
__ Male
__ Female
__ Undefined

Race (Check all that apply)
__ White __ Black
__ Asian
__ Native Hawaiian/Other Pacific Islander
__ American Indian/Alaskan Native
__ Unknown
__ Other: _____

Ethnicity
__ Hispanic
__ Non-Hispanic
__ Unknown
__ Other:
_____

Preferred Language:
_____

Primary Home Language:
_____

PATIENT LIVES WITH _____ **PATIENTS'S CELL:** _____

SIBLING'S NAME(S) AND DATE(S) OF BIRTH _____

□ **FATHER** □ **MOTHER** □ **GUARDIAN** **HOME PHONE:**

NAME: **CELL PHONE:**

ADDRESS: **DATE OF BIRTH:**

CITY/ZIP: **EMAIL:**

□ **FATHER** □ **MOTHER** □ **GUARDIAN** **HOME PHONE:**

NAME: **CELL PHONE:**

ADDRESS: **DATE OF BIRTH:**

CITY/ZIP: **EMAIL:**

FATHER'S/MOTHER'S EMPLOYER: WORK PHONE:

FATHER'S/MOTHER'S EMPLOYER: WORK PHONE:

Emergency Contact (other than parents) _____ Phone: _____

Preferred Pharmacy _____ Phone: _____

Primary Care Physician _____

PRIMARY: Insurance Company _____ Effective Date _____ Copay _____

Insured Parent's Name _____ ID # _____

Group # _____ Claims Address _____

SECONDARY: Insurance Company _____ Effective Date _____ Copay _____

Insured Parent's Name _____ ID # _____

Group # _____ Claims Address _____

By my signature below I acknowledge that I have received the WPHC Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can access my information. A no-show fee of $50 will be added to any no show appointment and/or appointments that are not canceled more than 24 hours before the appointment time. Please note: In order to control the costs of billing we request that office visits be paid at the time of service unless appropriate insurance information is provided. A finance charge of 1.0% will be added to your account on a monthly basis if your balance is 60 days or older. A minimum finance charge will be $.50 per month on any account older than 60 days. Total annual finance percentage will equal 12% on any account balance that is older than 60 days. (RCW 19.52) **I hereby certify that all of the above information is true. I agree to have medical information released for billing purposes to my insurance carrier and to billing personnel. I agree to pay for any charges not payable by my insurance plan. I furthermore, have read the above and understand that I am responsible for all medical and financial charges.**

Signed: _____ **Date:** _____