Hello. Welcome to Westminster Medical Clinic!

Please complete the following information to establish care as a New Patient. All of the items marked with an * are required items to complete.

Last name*: _____ **First name*:** _____ **MI*:** _____

Preferred name (if different than above): _____ **Date of birth*:** _____

Sex at birth*: ☐ Male ☐ Female
Gender: _____

Marital status*: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed

Address*: _____ **Apt/Unit:** _____

City*: _____ **State*:** _____ **Zip*:** _____

Email address*: _____
This will be the email address that will be linked to the Patient Portal.

Primary phone*: _____ ☐ Home ☐ Cell/mobile ☐ Work

Secondary phone: _____ ☐ Home ☐ Cell/mobile ☐ Work

How would you like to receive appointment reminder notifications?*
☐ Phone ☐ SMS/text[1] ☐ Both *OR* ☐ NO reminder notifications

Cell/mobile number (if not listed above): _____

[1]SMS/text messages may be subject to message or data fees charged by your mobile service carrier. Please contact your mobile service carrier to confirm any fees for SMS/text services.

Race*: ☐ American Indian, Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black, African American ☐ White ☐ Hispanic, Latino ☐ Other

Ethnicity*: ☐ Hispanic, Latino ☐ Not Hispanic, Latino

Consent to Release Personal Health Information (PHI)*
I authorize Westminster Medical Clinic to discuss and/or share information with the individual(s) listed below. I understand that I may add or remove individual(s) to this consent at any time by submitting a new consent. I agree that Westminster Medical Clinic may share all information related to:

1. Medical, diagnostic, imaging, and/or laboratory results
2. Appointment scheduling and billing

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OVER ⇨

Emergency contact*: _____

Relationship*: _____

Primary phone*: _____

Secondary phone: _____

Any hearing or visual barriers that we may accommodate? ☐ Yes ☐ No

Language preference *(if other than English)*: _____

Do you have <u>Medicaid (Health First Colorado)</u> as a PRIMARY or SECONDARY insurance? ☐ Yes ☐ No

Westminster Medical Clinic is NOT a Medicaid Provider, and CANNOT see patients. Per State Law, Westminster Medical Clinic cannot accept cash payments for services from Medicaid members.

PRIMARY INSURANCE*: _____

Is the patient the subscriber or primary policyholder?* ☐ Yes ☐ No **If no, please provide below information*

Subscriber last name: _____ First name: _____ MI:____

Date of birth: _____ Relationship to patient: _____

Address *(if different than patient)*: _____ Apt/unit: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Secondary phone: _____

SECONDARY INSURANCE: _____

Is the patient the subscriber or primary policyholder? ☐ Yes ☐ No **If no, please provide below information*

Subscriber last name: _____ First name: _____ MI:____

Date of birth: _____ Relationship to patient: _____

Address *(if different than patient)*: _____ Apt/unit: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Secondary phone: _____

To the best of my knowledge, the information above is accurate.

Patient Name (Print)*: _____

Legal Guardian Name (if the patient is a minor under 18 years of age): _____

Signature*: _____ **Date*:** _____