Whole Family Health Care
Cynthia Taylor, MD
PATIENT REGISTRATION FORM

PLEASE PRINT

PATIENT INFORMATION:

First Name _____ Last Name _____

Sex M___F___ Age_____ DOB___/___/_____ Social Security Number _____/_____/_____

Marital Status: Single_____Married_____Spouse's Name_____Widowed____Separated____Divorced___

Employer_____ Occupation_____

Home Address_____ City_____ Zip Code_____

Home Telephone (_____)_____Work/Alternate Telephone (_____)_____

Cell Phone (_____)_____ Email Address:_____

EMERGENCY INFORMATION: Please give us someone who **DOES NOT LIVE WITH YOU**, to contact in case of emergency:

Emergency Contact Name_____Relationship_____Telephone (_____)_____

GUARANTOR If someone other than the patient is responsible for charges, please provide the following information:

Name_____ Relationship_____

Address_____ Phone (_____)_____

HOUSEHOLD INFORMATION:

Please list **ALL PEOPLE** who live in the same house as the patient:

Name	Relationship	Date of Birth

Preferred Language:_____

What is your race? (Check all that apply.)

☐ Decline to Specify
☐ Hispanic or Latino origin or descent
☐ White
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Asian
☐ Other

Please read the following statement carefully before signing

I authorize treatment of the patient named above. I assign directly to Whole Family Health Care and Dr. Cynthia Taylor all insurance benefits to which the insured is entitled. I understand that I am financially responsible for all charges, whether or not paid by insurance. I have been informed of the $35 fee (per RCW 62A.3-515 & 520) on any checks returned unpaid by my bank. If the balance exceeds an amount I am able to pay in full, an agreed payment plan can be established, with 1% interest per month (per RCW 19.52) on the unpaid balance.

SIGNATURE_____ Date_____/_____/_____

RELATIONSHIP TO PATIENT_____