PALOUSE HEART CENTER
PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

David T. Jones, MD
825 SE Bishop Blvd. Suite 140
Pullman WA 99163-5517
Office (509) 336-7577
Fax (509) 336-7578

# PATIENT REGISTRATION

Patient's Legal Name: ______________________________ Last 4 Digits S.S. #: ________
(First) (Middle Initial) (Last)

Preferred Name: ______________________ Marital Status: ______________

Due to updated Federal guidelines, we are required to obtain specific patient information. Please make sure you answer questions 1-6. Thank you.

**(1) Patient's Birthdate:** ____________ **(2) Patient's Age:** _____ **(3) Patient's Gender**: ______

**(4) Race** (Check One)
- □ American Indian/Alaska Native
- □ Asian
- □ African American
- □ White
- □ Other Race
- □ Declined

**(5) Ethnicity** (Check One)
- □ Not Hispanic or Latino
- □ Hispanic or Latino
- □ Declined

**(6) Primary Language** (Please List)
- □ English
- □ ____________
- □ Declined

Home Address: ______________ City: ________ State: ____ Zip Code: ______

Mailing Address: ______________ City: ________ State: ____ Zip Code: ______

Home #: ____________ Work #: ____________ Cell#: ____________

Email: ______________________ Occupation: ______________

Employer Name & Address: ______________________________

## SPOUSE OR SIGNIFICANT OTHER INFORMATION

Name: ______________________________ DOB:______ Last 4 Digits S.S. #: ______
(First) (Middle Initial) (Last)

Address: ______________ City: ________ State: ____ Zip Code: ______

Home #: ____________ Work #: ____________ Cell #: ____________

Email: ______________________ Occupation: ______________

Employer: ______________________________

## EMERGENCY CONTACT INFORMATION

Name: ______________________________ Relation: ____________

Address: ______________________ City: __________ State: ____ Zip Code: ______

Home #: ____________ Work#: ____________ Cell #: ____________

## PHYSICIAN INFORMATION

Referring Provider: ______________________ Phone #: ____________

Primary Care Provider (If Different): ______________ Phone #: ____________

Other: ______________________ Phone #: ____________

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## PHARMACY INFORMATION

Preferred Pharmacy: ______________________________ Phone #: ____________________

Preferred Mail Order Pharmacy: ______________________________ Phone #: ____________________

## INSURANCE INFORMATION

**Primary Insurance:**______________________________ Effective Date: __________

Subscriber's Name: ______________________________ Birthdate: ____________________

Policy/ID # (Include Alpha Prefix, if applicable): ____________________ Group #: __________ Copay: ___

Address: ______________________________ City: ______________ State: __________ Zip Code: __________

Customer Service Phone #: ______________________________ Relationship to Patient: ______________

**Secondary Insurance** *(If Applicable)*: ______________________________ Effective Date: __________

Subscriber's Name: ______________________________ Birthdate: ____________________

Policy/ID # (Include Alpha Prefix, if applicable): ____________________ Group #: __________ Copay: ___

Address: ______________________________ City: ______________ State: __________ Zip Code: __________

Customer Service Phone #: ______________________________ Relationship to Patient: ______________

**Tertiary Insurance** *(If Applicable* **:** ______________________________ Effective Date: __________

Subscriber's Name: ______________________________ Birthdate: ____________________

Policy / ID # (Include Alpha Prefix, if applicable): ____________________ Group #: __________ Copay: ___

Address: ______________________________ City: ______________ State: __________ Zip Code: __________

Customer Service Phone #: ______________________________ Relationship to Patient: ______________

## Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Clinic Administrator and Privacy Officer at 509-332-6139.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information. **By my signature below, I acknowledge receipt of Notice of Privacy Practices.**

______________________________________________________________

Patient or legally authorized individual signature                    Date

______________________________________________________________

Printed name if signed on behalf of the patient                    Relationship (parent, legal guardian)

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Patient's Name: ________________________________________ Date of Birth: ___________

## CONSENT FOR ELECTRONIC COMMUNICATIONS

**E-mail, Text or Other Electronic Communications.** To provide the best care possible, Pullman Regional Hospital Clinic Network, LLC and its affiliates seek to communicate with its patients in a convenient and effective manner, including e-mail, text or other electronic means if requested by the patient and deemed appropriate by Pullman Regional Hospital Clinic Network, LLC. Please note that such communications sent through the internet or over phone systems may not be encrypted or secure, and could result in unauthorized persons accessing your information. If you would like Pullman Regional Hospital Clinic Network, LLC to communicate with you electronically despite these concerns, please indicate your preferred method of communication and sign below.

☐ **E-mail.** Use this e-mail address: ______________________________________

☐ **Text.** Use this text number: (______) ______- __________

☐ **Other Means** (subject to Pullman Regional Hospital Clinic Network, LLC's approval):

_______________________________________________________________________

Patient or legally authorized individual signature: _________________________________________________