Washington Health Institute
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Washington, DC 20017
Tel: (202) 525-5175
Fax: (202) 450-6088
www.DC-WHI.org

NEW PATIENT REGISTRATION

Welcome to the Washington Health Institute, your partner in health! Thank you for choosing us for your health care needs. This information will be used by our office to assist in optimizing your health care experience. Please be as thorough as possible with your answers. Let us know if you have any questions completing this registration form, we are happy to assist you.

CONTACT INFORMATION			
Last Name:			
First Name:			
Middle Name:			
Suffix:			
I go by Name:			
Address:1			
Address: 2			
APT Number:			
City:		State:	Zip Code:
Home Telephone:			
Cell Number:			
Work Number:			
Email Address:			
Date of Birth:	Month:	Day:	Year:

DC Ward in which you live:______________	☐ Don't know	☐ Not a DC Resident

Washington Health Institute will send correspondence through the patient portal, text messages, email address, and US Mail. All patients must activate the patient portal to communicate with the provider and the office and to request refills. If you need assistance, please ask the front desk for assistance.

EMERGENCY CONTACT 1

Field			
Last Name:			
Frist Name:			
Relationship to Patient:			
Address:1			
City:		State:	Zip Code:
Home Telephone:			
Cell Number:			
Work Number:			
Email Address:			

EMERGENCY CONTACT 2

Field			
Last Name:			
Frist Name:			
Relationship to Patient:			
Address:1			
City:		State:	Zip Code:
Home Telephone:			
Cell Number:			
Work Number:			
Email Address:			

<table>
<tr><th colspan="4">INSURANCE INFORMATION</th></tr>
<tr><td>Do you have health insurance?

☐ Yes
☐ No</td><td colspan="3">If you do not have insurance, you must meet with our case management department for insurance eligibility determination. You may be eligible for public benefits, reduced cost insurance, or for fees based on WHI’s sliding fee scale. In order to determine your eligibility, you must provide proof of income, family size, and residency documentation. Until we receive your documentation and eligibility, you will be responsible for the full fee for your services.</td></tr>
<tr><td colspan="4">If we do not take your insurance, we encourage you to select a provider who takes your insurance. Choosing to get your care with us will mean you will be charged for the full fee of your care, and you will need to seek reimbursement from your insurer.</td></tr>
<tr><td>Insurance Card:</td><td colspan="3">Provide a copy of the both the front and back of all your health insurance card.</td></tr>
<tr><td rowspan="5">Insurance Information:</td><td>Company:</td><td colspan="2"></td></tr>
<tr><td>Subscriber Number:</td><td colspan="2"></td></tr>
<tr><td>Group Number:</td><td colspan="2"></td></tr>
<tr><td>In whose names is your insurance?</td><td colspan="2"></td></tr>
<tr><td>When does your insurance start and end?</td><td>Start (MM)</td><td>End (MM)</td></tr>
<tr><td rowspan="5">Secondary Insurance Information:</td><td>Company:</td><td colspan="2"></td></tr>
<tr><td>Subscriber Number:</td><td colspan="2"></td></tr>
<tr><td>Group Number:</td><td colspan="2"></td></tr>
<tr><td>In whose names is your insurance?</td><td colspan="2"></td></tr>
<tr><td>When does your insurance start and end?</td><td>Start (MM)</td><td>End (MM)</td></tr>
</table>

DEMOGRAPHICS

WHI collects demographic information such as gender identify, pronouns you prefer to use, sexual orientation, race/ethnicity, housing and employment status, language spoken, and more to provide you with the best patient-centered care, in a culturally and linguistically responsive manner. All information is confidential and helps us to better care for you.

Sex Assigned at Birth:	Gender Identity:	Pronouns:
☐ Male ☐ Female ☐ Unknown **Do you identify as Transgender?** ☐ Yes ☐ No	☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Gender queer, neither exclusively male nor female ☐ Choose not to disclose ☐ Additional Gender Category or other, please specify:	☐ He/him/his/his/himself ☐ She/her/her/hers/herself ☐ they/them/their/theirs/ themselves ☐ ze/zir/zir/zirs/zirself ☐ xie/hir (“here”)/hir/ hirs/hirself ☐ co/co/cos/cos/cos ☐ en/en/ens/ens/enself ☐ ey/em/eir/eirs/emself ☐ yo/yo/yos/yos/yoself ☐ ve/vis/ver/ver/verself ☐ Another Pronoun, please specify:
Sexual Orientation:	**Marital Status:**	**Are you a Veteran of the US Military (Not Active Duty)?**
☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Do not know ☐ Choose not to disclose ☐ Something else, please describe:	☐ Divorced ☐ Married ☐ Partnered ☐ Single ☐ Unknown ☐ Legally Separated	☐ Yes ☐ No

What is your race? (check all that apply)		Ethnicity:

☐ American Indian or Alaska Native
☐ Asian
  ☐ Asian Indian
  ☐ Chinese
  ☐ Filipino
  ☐ Japanese
  ☐ Korean
  ☐ Vietnamese
  ☐ Other Asian
☐ Black or African American
	☐ Native Hawaiian or Other Pacific Islander
	  ☐ Native Hawaiian
	  ☐ Samoan
	  ☐ Guamanian or Chamorro
	  ☐ Other Pacific Islander
	☐ White
	☐ Other
		☐ Not Hispanic or Latino
		☐ Hispanic or Latino
		  ☐ Cuban
		  ☐ Mexican, Mexican American, Chicano/a
		  ☐ Puerto Rican
		  ☐ Another Hispanic, Latino/a, Spanish Origin
		☐ Other:

Is your housing status?	Employment Status	Student Status
☐ Stable ☐ Unstable ☐ Temporary ☐ Homeless ☐ Street ☐ Doubling up/coach surfing ☐ Transitional housing ☐ Homeless shelter ☐ Other	☐ Employed full-time ☐ Employed part-time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Reserved for national assignment ☐ Unknown	☐ Full-time student ☐ Not a student ☐ Part-time student

ACCESSIBILITY		
Preferred **spoken** language:	Preferred language for **reading**:	Deaf or hard of hearing?
☐ English ☐ Spanish ☐ Other, _________	☐ English ☐ SpanishOther, _________	☐ Yes ☐ No
Do you require an Interpreter? ☐ Yes ☐ No	Do you require an Interpreter? ☐ Yes ☐ No	Do you require an Interpreter? ☐ Yes ☐ No Preferred type of Interpreter? ☐ ASL live interpreter ☐ ASL video/remote interpreter
MEDICAL DOCUMENTATION		
Do you have an advanced health care directive?	Would you like more information about an advanced health care directive?	Have you signed a medical records release to get your medical records from your previous provider?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I attest the information on the form is correct to the best of my knowledge. I will provide WHI with updates to my information if it items change.

______________________________   ____________________

Signature   Date: