WESTERN WAKE WELLNESS

401 KEISLER DRIVE
SUITE 101
CARY NC 27518
919-378-1492
www.WesternWakeWellness.com

WESTERN WAKE WELLNESS, PLLC
ADULT REGISTRATION

PATIENT INFORMATION

Legal Name:_____ Nickname:_____

Today's Date:_____ Date of birth:____/____/_____ City of Birth: _____ Age:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Language: □ English □ Other:_____

Patient's Email Address:_____

The best way to contact me is: □ Phone □ Email/patient portal □ Postal mail

Sex at birth: □ Male □ Female **Gender**: □ Male □ Female □ Genderqueer or not exclusively male nor female

My pronouns are: □ She/hers □ He/his □ They/their **Do you identify as transgender?** □ Yes □ No □ Don't know

Do you think of yourself as: □ White □ Black or African American □ Asian □ American Indian or Alaska Native

(check all that apply) □ Native Hawaiian or Pacific Islander □ Other _____ □ I prefer not to answer

My ethnicity is: □ Hispanic or Latino □ Not Hispanic or Latino □ I prefer not to answer

Marital Status: □ Single □ Married □ Domestic Partnership □ Divorced □ Widowed

I identify as: □ Straight, Heterosexual □ Gay, Lesbian, Homosexual □ Bisexual □ Something Else □ Don't know

GUARANTOR INFORMATION (Person Responsible For Bill) **Please use full legal name**

Relationship to Patient: □ Self □ Spouse □ Parent □ Child □ Other:_____

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Date of birth:____/____/_____ Home Phone:_____ Social Security Number:_____

Employer Name & Address:_____

PRIMARY HEALTH INSURANCE (Please bring card with you to every appointment)

Insurance Company:_____

Policy Holder's Name:_____ Relationship to Patient:_____

Policy ID#:_____ Group#:_____ Effective Date:_____

Employer Name & Address:_____

SECONDARY INSURANCE

Insurance Company:_____

Policy ID#:_____ Group#:_____ Effective Date:_____

Which Pharmacy do you prefer to use for prescriptions?

Name / Address: _____

Who may we thank for referring you to our practice?

Acknowledgement of Receipt of Notice of Privacy Practices

I have Received a copy of the Notice of Privacy Practices for the above named practice.

Signature: **Date**:

Office Use Only **We were unable to obtain written acknowledgement of receipt of the Notice of Privacy Practices because:**

□ An emergency existed and a signature was not possible □ The individual refused to sign □ Other_____

□ A copy was mailed with a request for a signature by return mail □ Unable to communicate with patient due to _____