wesley Health Centers
JWCH INSTITUTE

PATIENT INFORMATION FORM

TODAY'S DATE: _____

NAME: DATE OF BIRTH:

Last First MI (MM/DD/YYYY)

GENDER IDENTITY: ☐ Male ☐ Female

CONTACT PHONE NUMBER: _____

RESIDENTIAL ADDRESS: _____

DRIVER LICENSE #: _____ (copy of ID required)

EMERGENCY CONTACT: _____

RELATIONSHIP TO THE PATIENT: ☐ Parent ☐ Spouse ☐ Relative ☐ Guardian ☐ Other

PRIMARY PHONE: _____

ETHNICITY: ARE YOU HISPANIC? ☐ Yes ☐ No

RACE: Select Applicable

☐ White ☐ Black/African American ☐ Native American/Alaskan ☐ Pacific Islander ☐ Unknown

☐ Asian ☐ Native Hawaiian ☐ Decline to State

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.

CONSENT TO TREAT

MEDICAL CONSENT

I hereby give my consent for medical treatment and/or services deemed necessary for the above named patient to receive medical treatment or health services by any member of the medical staff at Wesley Health Centers. This includes non-invasive and invasive diagnostic tests, procedures, and services, X-rays, laboratory services, and clinical services that are provided during the course of medical treatment to the patient.

SIGNATURE

_____ _____ _____

Patient, Parent, Guardian, or Authorized Representative | Relationship | Date