WEALTH BY HEALTH
STEPS FOR CHANGE FOUNDATION
1-888-996-9985
Info@wealthbyhealth.org

PATIENT REGISTRATION FORM

EVENT DATE: _____

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME: _____MIDDLE:_____

GENDER: ☐ M ☐ F AGE: _____ MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

STREET ADDRESS: _____CITY: _____

STATE: _____ ZIP CODE: _____ PHONE #: (_____) _____-_____

EMPLOYED? ☐ YES ☐ NO EMAIL ADDRESS: _____

MEDICAL HISTORY

1. ARE YOU CURRENTLY UNDER PHYSICIAN'S CARE? ☐ YES ☐ NO
   IF YES, FOR WHAT CONDITION(S) _____

2. ARE YOU CURRENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO
   IF YES, PLEASE LIST MEDICATIONS: _____

3. WOMEN: PREGNANT? ☐ YES ☐ NO

4. ALLERGIES? ☐ PENICILLIN ☐ CODEINE ☐ LATEX RUBBER ☐ ACRYLIC ☐ LOCAL ANESTHETICS
   ☐ OTHER: _____

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS):

_____

RELATIONSHIP TO PATIENT: _____PHONE NUMBER: _____

DO YOU HAVE MEDICAL/DENTAL INSURANCE COVERAGE? ☐ YES ☐ NO

DOCTOR'S NAME: _____

SERVICE: ☐ WESTERN MEDICINE ☐ CHINESE MEDICINE ☐ DENTAL CARE ☐ FLU VACCINE

HOW DID YOU HEAR ABOUT US?

☐ FRIEND ☐ NEWSPAPER ☐ RADIO ☐ ONLINE ☐ OTHER: _____

Please read, sign, and execute attached Patient Consent to Health Screening and Waiver of Liability before participation in WBHSFC's Free Medical Clinics.

WEALTH BY HEALTH STEPS FOR CHANGE FOUNDATION
CONSENT TO FREE MEDICAL CLINIC AND WAIVER OF LIABILITY

I understand, acknowledge, and agree to the following:

1. I am voluntarily participating in the Free Medical Clinic/Health Fair hosted by the Wealth By Health Steps For Change Foundation (WBHSFCF) on _____(date).
2. This Free Medical Clinic/Health Fair is being conducted by volunteer physicians, dentists, pharmacists and other health care professionals/assistants ("Volunteers") for my best interests, and is preliminary in nature only and is provided free of cost.
3. The Wealth By Health Steps For Change Foundation (WBHSFCF), its officers, members and the participating health care volunteers make no claims, representations nor guarantees with respect to the accuracy or precision of evaluation(s) due to the limited nature of the service provided.
4. It is my responsibility to follow up any recommendations that are made to me during this screening, and obtain follow up advice, testing, diagnosis and advice from my personal physician.
5. I agree to indemnify and hold harmless the participating Organizations including the WBHSFCF, authorities of the City and facility holding the Free Medical Clinic/Fair and Volunteers from any and all claims, liability and expenses (including attorney fees and other costs) arising out of advice given or not given, test conducted or any act or inaction on the part of the participating Organizations or Volunteers or any of them, during or after this Health Screening. The health screening process will be rendered by volunteers only; no compensation is expected or charged. By rendering my consent to this screening process, I understand I am not receiving medical services and therefore agree to indemnify and hold harmless Organizations including the WBHSFCF, authorities of the City and facility holding the Free Medical Clinic/Fair and Volunteers from any and all claims, liabilities, and expenses including attorney fees and court costs, arising from my participation or the advice given or not given, test(s) conducted or as a result of this health screening. I understand that the activities of this Free Medical Clinic/Fair may be filmed or photographed and such films or photographs may contain my picture or likeness. I further understand that such films or photographs may be used for various purposes including films and publications for non-commercial and/or commercial purposes. I understand that I have right of privacy and a right of physician/patient privilege. I expressly waive my rights of privacy and physician/patient privilege and authorize the filming or photographing of my person or likeness for usage including but not limited to films, published articles for commercial as well as non-commercial purposes. I UNDERSTAND THAT MY SEEKING THE ADVICE OF PHYSICIANS AT THIS HEALTH FAIR DOES NOT CREATE A PHYSICIAN/PATIENT RELATIONSHIP BETWEEN MYSELF AND ANY PHYSICIAN OR HEALTH CARE PROVIDER AT THIS FREE MEDICAL CLINIC/ FAIR.
6. I acknowledge that I have read this Waiver, or have had it read to me, I have understood the provisions, or have had it explained to me, and my waiver is made knowingly, voluntarily and intelligently.

Signature of Patient _____ Signature of Witness_____

Name of Patient _____ Name of Witness_____

Date _____ Date_____