WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT
Cedarwood Hall - ROOM 221
VALHALLA NY 10595-1689

Patient's Name _____

D.O.B. _____ **Sex** **Male** ☐ **Female** ☐

SS # _____ **WIHD#**_____

HEALTH SERVICES REGISTRATION FORM

Please Complete All Sections * Forms May Be Mailed to the Address Above or Faxed to 914-493-1675*

New Registration ☐ **Registration Update** ☐ **Today's Date**

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **Fax (if available):**_____

Email Address _____ ☐ **Patient** ☐ **Parent/Guardian**

***For Government Reporting Purposes*:** **Race/Ethnicity:** ☐ **White** ☐ **Black/African American** ☐ **Asian**
☐ **Other Specify** _____ **Are you Hispanic or Latino?** ☐ **Yes** ☐ **No**

Preferred Language:_____ **Pharmacy Name and Address:**_____

Do you have an Advance Directive? ☐ **Yes** ☐ **No** **If Yes, does WIHD have a copy?** ☐ **Yes** ☐ **No**
Do you have a Health Care Proxy? ☐ **Yes** ☐ **No** **If Yes, does WIHD have a copy?** ☐ **Yes** ☐ **No**
If you would like to learn more about Advance Directives or Health Care Proxy please let your provider know*

Parent/Guardian/Foster Parent Name _____ **Relationship to Patient**_____

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

Home Phone _____ **Work Phone** _____

Parent/Guardian/Foster Parent Name _____ **Relationship to Patient**_____

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

Home Phone _____ **Work Phone** _____

Medicaid No. _____ **Medicare No.** _____

Private Insurance Co. _____ **Policy No.** _____

Name of Insured _____ **Relationship to Patient** _____

Other Insurance Co. _____ **Policy No.**_____

Name of Insured _____ **Relationship to Patient** _____

Agency Name:_____ **House Name** _____

Contact _____ **Phone No.** _____ **Fax No.**_____

Address _____ **City** _____ **State** _____ **Zip** _____

Name and phone of Patient's Primary Care Provider:_____ **If none, please check** ☐

Name and phone of Patient's Dental Care Provider:_____ **If none, please check** ☐

Service/Services Requested:_____