

PATIENT-CLIENT REGISTRATION FORM



PATIENT DEMOGRAPHICS			
Full Legal Name			
(Last)	(First)	(MI)	
Date of Birth	Age	Last Name at Birth	
Social Security #	Driver's License #		
Gender/ Gender Preference <i>(please check one)</i> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/Male-to-Female			
Sexual Orientation <i>(please check one)</i> <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Something else <input type="checkbox"/> Choose not to disclose			
Patient's Sex Assigned at Birth <i>(please check one)</i> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown			
Pronoun Preference <i>(please check one)</i> <input type="checkbox"/> He/His <input type="checkbox"/> She/Her <input type="checkbox"/> They/Their <input type="checkbox"/> Ze/Zir <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown			
Mailing Address			
(Address)	(City)	(State)	(Zip)
Home Address <i>(If different)</i>			
(Address)	(City)	(State)	(Zip)
Phone <i>(please check your primary phone)</i>			
<input type="checkbox"/> Home Phone: _____		<input type="checkbox"/> Cell Phone: _____	
<input type="checkbox"/> Message: _____			
Preferred Communication Method <i>(for appointment-related contact)</i> <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email			
Occupation	Employer	Phone	
Employment Status <i>(please check one)</i>			
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal/Temporary <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed			
Name of Spouse/Significant Other*			Date of Birth
*If you wish to permit the above person(s) to discuss your medical care and/or billing matters, please include this person on the Authorization for the Disclosure of Information form.			
Responsible Party Name			Date of Birth
<i>(Complete if other than patient)</i>			
Social Security #	Employer	Phone	
INSURANCE INFORMATION Please provide copies of your insurance card(s)			
Name of Primary Insurance			
Group #	Policy #		
Policyholder (PH) Name	PH Date of Birth		
PH Social Security #	PH Relationship to Patient		
Name of Secondary Insurance <i>(If applicable)</i>			
Group #	Policy #		
Policyholder (PH) Name	PH Date of Birth		
PH Social Security #	PH Relationship to Patient		

PATIENT-CLIENT REGISTRATION FORM



PATIENT/CLIENT STATISTICS	
<p>As a Nonprofit Organization, we receive grant dollars and we are <u>required</u> to gather the following statistics about the patients/clients we serve on an annual basis. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.</p>	
<p align="center">Check One for Each Question (answer regarding the patient)</p>	
Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> ASL <input type="checkbox"/> Other (specify)	
Does client need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, circle which: <input type="checkbox"/> Foreign Language <input type="checkbox"/> Hearing	
Would you be better served in a language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Student Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a Student	
Is the patient a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Immediate Family Member a Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referral Source <input type="checkbox"/> Outreach Coordinator <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> News Media-Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Facebook <input type="checkbox"/> Ad-Digital <input type="checkbox"/> Direct Mail <input type="checkbox"/> Billboard <input type="checkbox"/> Other (specify)	
Please indicate the stability of your current living status <input type="checkbox"/> Permanent (Stable) <input type="checkbox"/> Temporary (Unstable)	
Current Living Situation <input type="checkbox"/> Own Home <input type="checkbox"/> Rent <input type="checkbox"/> Temporary Housing <input type="checkbox"/> Staying with friends/relatives (double up) <input type="checkbox"/> Public Housing <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Other	
Agricultural Work Status <input type="checkbox"/> Non-Agricultural <input type="checkbox"/> Agricultural-Seasonal <input type="checkbox"/> Agricultural-Migrant <input type="checkbox"/> Agricultural-Employed Year-Round <input type="checkbox"/> Retired Farmworker	
Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Refuse to Report	
Client's Current Tribal Affiliation: <input type="checkbox"/> Not Applicable <input type="checkbox"/> Burns Paiute Tribe <input type="checkbox"/> Cow Creek Band of Umpqua Tribe <input type="checkbox"/> Confederated Tribes of Grant Ronde <input type="checkbox"/> Confederated Tribes of Coos/Lower Umpqua/Siuslaw <input type="checkbox"/> Confederated Tribes of Umatilla <input type="checkbox"/> Coquille Indian Tribes <input type="checkbox"/> Confederated Tribes of Warm Springs <input type="checkbox"/> Other (please specify):	
What is your gross (before taxes) household income? Per Month: <u>OR</u> Per Year:	
How many people are in your household, including yourself?	
Do you receive TANF Cash Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Highest School Grade Client Completed:	

 Patient or Guardian / Personal Representative signature (circle one)

 Date

 Printed name of Patient

 Relationship, if not Patient