PATIENT-CLIENT REGISTRATION FORM

adapt
Integrated Health Care

PATIENT DEMOGRAPHICS

Full Legal Name
(Last) (First) (MI)

Date of Birth **Age** **Last Name at Birth**

Social Security # **Driver's License #**

Gender/ Gender Preference *(please check one)* ☐ Male ☐ Female ☐ Other ☐ Choose not to disclose
☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female

Sexual Orientation *(please check one)*
☐ Straight ☐ Bisexual ☐ Lesbian or Gay ☐ Something else ☐ Choose not to disclose

Patient's Sex Assigned at Birth *(please check one)* ☐ Female ☐ Male ☐ Unknown

Pronoun Preference *(please check one)*
☐ He/His ☐ She/Her ☐ They/Their ☐ Ze/Zir ☐ Decline to Answer ☐ Unknown

Mailing Address
(Address) (City) (State) (Zip)

Home Address *(If different)*
(Address) (City) (State) (Zip)

Phone *(please check your primary phone)*

☐ Home Phone: _____ ☐ Cell Phone: _____

☐ Message Phone: _____ ☐ Email: _____

Preferred Communication Method *(for appointment-related contact)* ☐ Phone ☐ Text ☐ Email

Occupation **Employer** **Phone**

Employment Status *(please check one)*
☐ Full-Time ☐ Part-Time ☐ Seasonal/Temporary ☐ Self-Employed ☐ Retired ☐ 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
(*Complete if other than patient*) **Date of Birth**

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 *(If applicable)*

Group # **Policy #**

Policyholder (PH) Name **PH Date of Birth**

PH Social Security # **PH Relationship to Patient**

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PATIENT/CLIENT STATISTICS

As a Nonprofit Organization, we receive grant dollars, and we are required 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.

Check One for Each Question *(answer regarding the patient)*

Primary Language ☐ English ☐ Spanish ☐ ASL ☐ Other (specify)

Does client need an interpreter? ☐ Yes ☐ No If yes, circle which: ☐ Foreign Language ☐ Hearing

Would you be better served in a language other than English? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Student Status ☐ Full-Time ☐ Part-Time ☐ Not a Student

Is the patient a Veteran? ☐ Yes ☐ No **Immediate Family Member of a Veteran** ☐ Yes ☐ No
Dependent Child of Veteran? ☐ Yes ☐ No **Spouse / Domestic Partner of Veteran?** ☐ Yes ☐ No ☐ **Unknown**

Referral Source ☐ Outreach Coordinator ☐ Friend ☐ Relative ☐ News Media-Newspaper ☐ Radio
☐ Television ☐ Facebook ☐ Ad-Digital ☐ Direct Mail ☐ Billboard

Please indicate the stability of your current living status ☐ Permanent (Stable) ☐ Temporary (Unstable)

Current Living Situation ☐ Own Home ☐ Rent ☐ Temporary Housing ☐ Staying with friends/relatives (double up)
☐ Public Housing ☐ Transitional Housing ☐ Shelter ☐ Street ☐ Other

Agricultural Work Status ☐ Non-Agricultural ☐ Agricultural-Seasonal ☐ Agricultural-Migrant
☐ Agricultural-Employed Year-Round ☐ Retired Farmworker

Are you Hispanic or Latino? ☐ Yes ☐ No

Race *(Check all that apply)* ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian
☐ Other Pacific Islander ☐ More than one race ☐ Refuse to Report

Client's Current Tribal Affiliation: ☐ **Not Applicable**
☐ Burns Paiute Tribe ☐ Cow Creek Band of Umpqua Tribe ☐ Confederated Tribes of Grant Ronde
☐ Confederated Tribes of Coos/Lower Umpqua/Siuslaw ☐ Confederated Tribes of Umatilla
☐ Coquille Indian Tribes ☐ Confederated Tribes of Warm Springs ☐ Other (please specify):

What is your gross (before taxes) household income? Per Month: **OR** Per Year:

How many people are in your household, including yourself?

Do you receive TANF Cash Benefits? ☐ Yes ☐ No

Highest School Grade Client Completed:

Patient or Guardian / Personal Representative signature (circle one) **Date**

Printed name of Patient **Relationship, if not Patient**