NEW PATIENT-CLIENT REGISTRATION FORM

PATIENT INFORMATION

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

Preferred Name:
(Last) (First) (MI)

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

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

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: ______________________________

Patient's Occupation: **Employer:**

Employer's Phone:

Employment Status *(check one):* ☐ Full-Time ☐ Part-Time ☐ Seasonal/Temporary ☐ Self-Employed
☐ Retired ☐ Unemployed ☐ Active Military ☐ Disabled

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

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 INFORMATION
As a non-profit organization, we receive grant funds and are required to gather the following information each year. The information you provide is confidential. **Please Check One for Each Question (answer regarding the patient).**
Primary Language: ☐ English ☐ Spanish ☐ ASL ☐ Other *(specify):*
Does patient need an interpreter? ☐ Yes ☐ No If yes, which: ☐ Foreign Language ☐ Hearing
Would you be better served in a language other than English? ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Domestic Partner
Is the patient 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
Patient Housing Status: ☐ Vehicle ☐ Unstable ☐ Temporary ☐ Stable/Permanent ☐ Recovery Center ☐ Other
Homeless Status: ☐ At risk for homeless ☐ Child at risk for homeless ☐ Currently not homeless (was in last 12 mo) ☐ Homeless unknown shelter ☐ Living in shelter ☐ Living with others ☐ Not homeless ☐ Permanent supportive housing ☐ Single occupancy hotel ☐ Street, camp, bridge ☐ Transitional housing ☐ Veteran at risk for homeless
Public Housing (Section 8/HUD): ☐ Yes ☐ No
Migrant / Seasonal: ☐ Migrant ☐ Seasonal ☐ Neither
Are you Hispanic or Latino? ☐ Yes ☐ No
Race *(check all that apply):* ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Alaska Native ☐ American Indian ☐ Refuse to Report
Patient's Current Tribal Affiliation: ☐ **Not Applicable** ☐ Burns Paiute Tribe ☐ Cow Creek Band of Umpqua Tribe ☐ Confederated Tribes of Grant Ronde ☐ Coquille Indian Tribes ☐ Confederated Tribes of Coos/Lower Umpqua/Siuslaw ☐ Confederated Tribes of Umatilla ☐ Confederated Tribes of Warm Springs ☐ Other *(specify)*
Do you receive TANF Cash Benefits? ☐ Yes ☐ No
Source of Income *(check one):* ☐ Wages/Salary ☐ Public Assistance ☐ Retirement/Pension/SSI ☐ Disability/SSDI ☐ Other *(specify):*
Highest School Grade Patient Completed:

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ADDITIONAL PATIENT INFORMATION (please answer all questions)
Adapt is a non-profit organization committed to serving the needs of our community. This information will help us access additional grants to continue helping uninsured and underserved residents and to identify patients who may qualify for special programs or services. The information will become part of your confidential patient record.
What is your gross (before taxes) household income? $ *(check one)* ☐ Month ☐ Year
How many people are in your household, including yourself?
Patient's Sexual Orientation *(check one):* ☐ Straight/Heterosexual ☐ Bisexual ☐ Something else ☐ Don't Know ☐ Choose not to disclose ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Queer ☐ Omnisexual ☐ Asexual
Patient's Gender Identity *(check one):* ☐ Female ☐ Male ☐ Transgender (F) ☐ Transgender (M) ☐ Other ☐ Choose not to disclose ☐ Nonbinary/Gender Queer ☐ Questioning ☐ Two Spirit
Patient's Sex Assigned at Birth *(check one)*: ☐ Female ☐ Male ☐ Intersex ☐ Not recorded on birth certificate
Pronoun Preference *(check one):* ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ ze/hir/hirs ☐ ey/em/eirs ☐ xe/xm/xyrs ☐ ve/vir/vis ☐ Other ☐ patient's name ☐ decline to answer ☐ unknown

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

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