

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):			
<input type="checkbox"/> Home Phone: _____		<input type="checkbox"/> Cell Phone: _____	
<input type="checkbox"/> Message Phone: _____		<input type="checkbox"/> Email: _____	
Patient's Occupation:		Employer:	
Employer's Phone:			
Employment Status (check one): <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 <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled			
Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a Student			
Responsible Party Name (complete if other than patient): _____			
Date of Birth: _____		Social Security #: _____	
Employer: _____		Phone: _____	
INSURANCE INFORMATION (Provide copies of your insurance cards)			
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: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> ASL <input type="checkbox"/> Other (<i>specify</i>):
Does patient need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, 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"/> Legally Separated <input type="checkbox"/> Domestic Partner
Is the patient a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent Child of Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse/Domestic Partner of Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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
Patient Housing Status: <input type="checkbox"/> Vehicle <input type="checkbox"/> Unstable <input type="checkbox"/> Temporary <input type="checkbox"/> Stable/Permanent <input type="checkbox"/> Recovery Center <input type="checkbox"/> Other
Homeless Status: <input type="checkbox"/> At risk for homeless <input type="checkbox"/> Child at risk for homeless <input type="checkbox"/> Currently not homeless (was in last 12 mo) <input type="checkbox"/> Homeless unknown shelter <input type="checkbox"/> Living in shelter <input type="checkbox"/> Living with others <input type="checkbox"/> Not homeless <input type="checkbox"/> Permanent supportive housing <input type="checkbox"/> Single occupancy hotel <input type="checkbox"/> Street, camp, bridge <input type="checkbox"/> Transitional housing <input type="checkbox"/> Veteran at risk for homeless <input type="checkbox"/> Unknown
Public Housing (Section 8/HUD): <input type="checkbox"/> Yes <input type="checkbox"/> No
Migrant / Seasonal: <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> Neither
Patient's Ethnic Group: <input type="checkbox"/> Hispanic/Latino/a <input type="checkbox"/> Non-Hispanic/Latino/a <input type="checkbox"/> Decline to answer <input type="checkbox"/> Unknown
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"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Decline to answer
Patient'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"/> Coquille Indian Tribes <input type="checkbox"/> Confederated Tribes of Coos/Lower Umpqua/Siuslaw <input type="checkbox"/> Confederated Tribes of Umatilla <input type="checkbox"/> Confederated Tribes of Warm Springs <input type="checkbox"/> Other (<i>specify</i>)
Do you receive TANF Cash Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
Source of Income (check one): <input type="checkbox"/> Wages/Salary <input type="checkbox"/> Public Assistance <input type="checkbox"/> Retirement/Pension/SSI <input type="checkbox"/> Disability/SSDI <input type="checkbox"/> Other (<i>specify</i>):
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 to M) Transgender (M to F)
 Other Choose not to disclose Nonbinary/Gender Queer Questioning Two Spirit

Patient's Sex Assigned at Birth (check one): Female Male Intersex Unknown
 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