PATIENT REGISTRATION FORM FOR PATIENTS 18YRS OR OLDER

Thank you for selecting us for your healthcare provider! In order to serve you, we need the following information. **Please print**.

PATIENT INFORMATION			
Legal Last Name:	Legal First:	Middle:	Birth Date:
Preferred Name:		Pronouns:	Sex at birth: ☐ Male ☐ Female

Race: ☐American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Decline to Answer
☐Native Hawaiian or Other Pacific Islander ☐ White, not Hispanic ☐ Hispanic

ADDRESS				
Street Address:	Apt. #:	City/Town:	State:	Zip Code:
Mailing Address (If different):	Apt. #:	City/Town:	State:	Zip Code:

Phone 1: ☐ Home ☐ Cell ☐ Cell Mom ☐ Cell Dad		Phone 2: ☐ Home ☐ Cell ☐ Cell Mom ☐ Cell Dad	
Phone 3: ☐ Work ☐ Other:		Phone 4: ☐ Work ☐ Other:	
Employer:	Social Security:	Email Address:	
	Preferred Language:	Need Interpreter? ☐ Yes ☐ No	

Resides with: : ☐ Mother ☐ Father ☐ Both Parents ☐ Resource Parent ☐ Legal Guardian ☐ Other:

EMERGENCY CONTACT	
Name:	Relationship to Patient:
Primary Telephone Number:	Secondary Telephone Number:

BILLING INFORMATION	
☐ Private Pay (No Insurance)	OHP: ☐ OHSU Health Services ☐ Care Oregon ☐ Yamhill Coordinated Care ☐ DMAP **Client ID #:** _____
☐ INSURANCE (Primary) Effective Date: ____/____/____ Insurance Name: _____ Subscriber Name: _____ DOB: ___/____/____ Policy #: _____ Group #: _____ Copay $: _____	☐ INSURANCE (Secondary) Effective Date: ____/____/____ Insurance Name: _____ Subscriber Name: _____ DOB: ____/____/____ Policy #: _____ Group #: _____ Copay $: _____

Notice of Privacy: I acknowledge that I have access to a complete copy of Hillsboro Pediatric Clinic LLC's (HPC) "Notice of Privacy Practices," which describes in detail how my medical information may be used and disclosed and how I can get access to my health information.

Pharmacy: I hereby authorize HPC to electronically send prescriptions to a participating pharmacy of my choice. HPC may electronically receive information regarding my prescription history, drug interactions, prior authorization requirements or required substitutions.

Pharmacy Name: _____Location: _____

Patient Centered Primary Care Home: As a Patient Centered Primary Care Home ("Medical Home"), HPC is committed to providing the highest quality patient centered care. HPC care will be delivered by a team of health care professionals including Physicians and Nurse Practitioners, Registered Nurses, Medical Assistants and other skilled staff. I will be encouraged and supported as I become involved in my care. The goal is to ensure that my healthcare needs are coordinated so that I have the best possible health outcome.

Signature **Print Name** **Relationship to Patient** **Date**