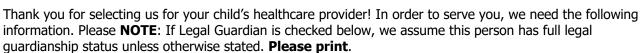
## PATIENT REGISTRATION FORM





Legal First:   Middle:   Birth Date:   Preferred Name:   Preferred Name:   Preferred Name:   Pronouns:   Pronouns:   Sex at birth:   Make   Premake   Make   Premake   Make   Premake   Make   Premake   Make   Premake   Make   Premake   Preferred Name:   Preferred	PATIENT INFORMATION										
Race:	Legal Last Name:	Middle:				Birth Date:					
Native Hawaisian or Other Pacific Islander   White, not Hispanic   Hispanic   Hispanic rulatino   Not Hispanic or Latino   Not Hispanic or Latino   Decline to answer   How did you hear about us?	Preferred Name:				Pronouns:						
Apt. #:   City/Town:   State:   Zip Code:											
Apt. #:   City/Town:   State:   Zip Code:			swer How did you hear about us?								
Resides with: (check all that apply)	ADDRESS WHERE PATIENT LIVES										
Contact Name:   Contact Name	Street Address:			Apt. #:	City/Town:		State	:	Zip Code:		
Relationship to Patient: (check all that apply)											
Last Name:   First Name:   Middle:   Birthdate:											
Apt. #:   City/Town:   State:   Zip Code:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			an Mothe		Resource Pare	nt 🗀				
Street Address:   Same as above		First Nan	ne:		Middle:			Birtho	late:		
Employer:    Social Security Number:   Email Address (1):   Preferred Language:   Need interpreter?   No   Yes   No   No   No   Yes   No   No   No   Yes   No   No   No   Yes   No   No   Yes   No   No   Yes   No   No   No   Yes   No   No   No   No   No	Mailing Address:			Apt. #:	City/Town: State:		:	Zip Code:			
Preferred Language:	Street Address:   Same as above			Apt. #: City/Town:		State:		Zip Code:			
Yes   No   No   No   No   No   No   No   N	Employer:			Social Security Number:			Emai	Email Address (1):			
Contact   Cont		Preferred Lan	guage:	Jage:							
Relationship to Patient: (check all that apply)											
Mailing Address:   Same as above	Relationship to Patient: (check all that apply)	Led					nt 🗀	DHS	Other:		
Employer:   Social Security Number:   Email Address (2):		First Nan	ne:		Middle:			Birtho	late:		
CONTACT METHOD	Mailing Address:   Same as above			Apt.#:	t.#: City/Town: State:		:	Zip Code:			
Phone 1:	Employer:			Social Security Number:			Email Address (2):				
Phone 1:	CONTACT METHOD										
Phone 3:	Phone 1:	☐ Home	<u> </u>					ППн	lome [	Cell	
Work Mom   Work Dad   Other	☐ Cell Mom										
BILLING INFORMATION  OHP: OHSU Health Services CareOregon Yamhill Coordinated Care DMAP  Client ID #:  INSURANCE (Primary) Effective Date: /_/ Insurance Name: Insurance Name: DOB: /_/_ Subscriber Name: DOB: /_/_ Policy #: Group #: Copay: \$ C	I <u></u>									」Work Dad	
Client ID #:  INSURANCE (Primary) Effective Date://  Insurance Name: Insurance Name:  Subscriber Name: DOB:/_/  Policy #: Copay: \$ Group #: Copay: \$ Copay: \$											
Client ID #:  INSURANCE (Primary) Effective Date:// INSURANCE (Secondary) Effective Date:/_/  Insurance Name: Insurance Name:  Subscriber Name: DOB:/_/ Subscriber Name: DOB:/_/  Policy #: Policy #: Group #: Copay: \$	Self-Pay (No Insurance)				OHP:	OHSU Health Service	es	П	CareOregon		
Client ID #:  INSURANCE (Primary) Effective Date://_ Insurance Name: Insurance Name: Subscriber Name: DOB://_  Policy #: Copay: \$ Group #: Copay: \$	_ com ray (tro insurance)										
☐ INSURANCE (Primary)         Effective Date://_         Insurance (Secondary)         Effective Date://_           Insurance Name:         Insurance Name:         DOB://_           Subscriber Name:         DOB://_         Policy #:           Policy #:         Group #:         Copay: \$											
Insurance Name:											
Subscriber Name:       DOB:											
Policy #:       Policy #:         Group #:       Group #:         Copay: \$       Copay: \$											
Group #: Copay: \$ Group #: Copay: \$											
Signature Print Name Relationship to Patient Date	Group #: Copay: \$				Group #: Copay: \$						
	Signature Print N			lame		Relation	Relationship to Patient				