Patient Registration

1. PATIENT DEMOGRAPHICS

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

Social Security # _____ **Date of Birth** _____ **Age** _____

Gender/ Gender Preference *(please circle one)*

Male Female Other Choose not to disclose
Transgender Male/Female-to-Male Transgender Female/Male-to-Female

Sexual Orientation *(please circle one)*

Straight (not lesbian or gay) Lesbian or gay Bisexual
Something else Don't know Choose not to disclose

Pronoun Preference *(please circle one)* He She

Mailing Address _____ **City** _____ **State** _____ **Zip**_____

Home Address _____ **City** _____ **State** _____ **Zip**_____
If different

Email Address *(for patient portal)* _____

Home Phone _____ **Cell Phone** _____ **Message Phone**_____
Please circle primary phone

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

Occupation _____ **Employer**_____ **Phone**_____

Employment Status *(please circle one)*

Full-Time Part-Time Seasonal/Temporary
Self Employed Retired Unemployed

Name of Spouse/Significant Other* _____ **Date of Birth** _____

Responsible Party Name* *Complete if other than patient* _____**Date of Birth** _____

Social Security #_____**Phone** _____ **Employer** _____

**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 (following).*

SouthRiver Community Health Center • P.O. Box 12 • 671 SW Main St. Winston, OR 97496 • 541.492.4550 • Fax: 541.492.4553 • www.south-river.org

2. INSURANCE INFORMATION Please provide copies of your insurance card(s)

Name of Primary Insurance_____ **Policy** _____

Group # _____

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

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

Name of Secondary Insurance_____ **Policy #** _____
If applicable

Group # _____

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

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

3. PATIENT STATISTICS

As a Federally Qualified Health Center, we are able to offer services to all our patients, including those who are uninsured or underinsured, through the use of federal grant funds. In order to receive grant dollars we are required to gather the following statistics about the patients 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.

Circle one for each question *(answer regarding the patient)*

Primary Language English Spanish ASL Other (Please specify) _____

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

Referral Source Outreach Coordinator Patient Friend Relative Radio Newspaper Yellow Pages

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 (doubling up)	
Public Housing	Transitional Housing	Shelter	Street	Other _____

Agricultural Work Status

Non-Agricultural	Agricultural-Seasonal	Agricultural-Migrant
Agricultural-Employed Year-Round		Retired Farmworker

SouthRiver Community Health Center • P.O. Box 12 • 671 SW Main St. Winston, OR 97496 • 541.492.4550 • Fax: 541.492.4553 • www.south-river.org

Are you Hispanic or Latino? Yes No

Race (Circle all that apply)

White	Black/African American	Asian	American Indian/Alaska Native
Native Hawaiian	Other Pacific Islander	More than one race	Refuse to report

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

How many people are in your household, including yourself? _____

4. MINOR PATIENTS ONLY Additional Information

Mother's Name_____ **Mother's Employer** _____

Mother's Date of Birth_____ **Social Security #**_____**Phone**_____

Mother's Address_____

Father's Name_____ **Father's Employer** _____

Father's Date of Birth_____ **Social Security #**_____ **Phone** _____

Father's Address_____

_____ _____

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

_____ _____

Printed name of Patient **Printed name of Signatory and relationship, if not Patient**

SouthRiver Community Health Center • P.O. Box 12 • 671 SW Main St. Winston, OR 97496 • 541.492.4550 • Fax: 541.492.4553 • www.south-river.org