NEHALEM BAY HEALTH CENTER REGISTRATION FORM

PATIENT INFORMATION

Received by: _____
Entered by: _____

NAME (FIRST, MIDDLE, LAST): _____PREFERRED NAME: _____

HAVE YOU BEEN KNOW BY ANY OTHER NAMES IN THE PAST (I.E. MAIDEN NAME, MARRIED NAME, ALIASES)?

YES NO IF YES, PLEASE LIST THOSE NAMES HERE: _____

SSN: _____ GENDER: _____ BIRTHDATE: _____

MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHYSICAL ADDRESS: _____

CITY, STATE, ZIP CODE: _____

HOME PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE? Y N**

CELL PHONE: _____ MAY WE LEAVE A DETAILED MESSAGE? Y N

WORK PHONE: _____ MAY WE LEAVE A DETAILED MESSAGE? Y N

EMAIL ADDRESS: _____

HAVE YOU EVER SERVED IN THE ARMED SERVICES? Y N

EMPLOYMENT STATUS (CIRCLE ONE): FULL-TIME PART-TIME UNEMPLOYED RETIRED CHILD

CURRENT EMPLOYER (IF APPLICABLE): _____

WOULD YOU LIKE TO RECEIVE INFORMATION ON OUR UPCOMING CLASSES, EVENTS, NEWS VIA EMAIL? Y N

How did you hear about Nehalem Bay Health Center?
_____

Name: _____ DOB: _____ Date: _____

INSURANCE

DO YOU HAVE INSURANCE? Y N

PRIMARY MEDICAL INSURANCE: _____ EFFECTIVE DATE: _____

ID # _____ GROUP # _____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: _____

SECONDARY MEDICAL INSURANCE: _____ EFFECTIVE DATE: _____

ID # _____ GROUP # _____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: _____

DENTAL INSURANCE: _____ EFFECTIVE DATE: _____

ID # _____ GROUP # _____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: _____

Name: _____ DOB: _____ Date: _____

GUARANTOR ACCOUNT / RESPONSIBLE PARTY FOR PAYMENT (IF DIFFERENT FROM PATIENT)

NAME (FIRST, MIDDLE, LAST): _____

SSN: _____ **GENDER:** _____ **BIRTHDATE:** _____

MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

EMPLOYMENT STATUS (CIRCLE ONE): FULL-TIME PART-TIME UNEMPLOYED RETIRED N/A

CURRENT EMPLOYER (IF APPLICABLE): _____

HOME PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE? Y N**

CELL PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE? Y N**

WORK PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE? Y N**

As a Federally Qualified Health Center, we are required to collect and update this information annually.

Please complete the information below.

EMERGENCY CONTACT

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP TO YOU:** _____

HOME PHONE: _____ **CELL PHONE:** _____

Name: _____ DOB: _____ Date: _____

ANNUAL HOUSEHOLD INCOME

FAMILY SIZE: _____

YEARLY INCOME (CIRCLE RANGE): $0 $1,000-$10,000 $10,001-$20,000 $20,001-$30,000 $30,001-$40,000

$40,001-$50,000 $50,001-$60,000 $60,001-$70,000 $70,001-$80,000 $80,001-$90,000 $90,001-$98,500

ADDITIONAL INFORMATION

PREFERRED LANGUAGE: _____ **DO YOU NEED AN INTERPRETER? Y N**

VISUALLY IMPAIRED? Y N **HARD OF HEARING? Y N**

DO YOU CONSIDER YOURSELF HOMELESS? Y N **ARE YOU A MIGRANT WORKER? Y N**

ETHNICITY (CIRCLE ALL THAT APPLY):

NON-HISPANIC MEXICAN, MEXICAN AMERICAN, CHICANO/A CUBAN PUERTO RICAN

ANOTHER HISPANIC, LATINO/A OR SPANISH ORIGIN UNKNOWN DECLINE TO ANSWER

RACE/HERITAGE (CIRCLE ALL THAT APPLY):

ALASKAN NATIVE AMERICAN INDIAN ASIAN INDIAN BLACK/AFRICAN AMERICAN CHINESE

FILIPINO GUAMANIAN OR CHAMORRO JAPANESE KOREAN NATIVE HAWAIIAN OTHER ASIAN

OTHER PACIFIC ISLANDER SAMOAN VIETNAMESE WHITE UNKNOWN DECLINE TO ANSWER