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| **Patient Information** | | | | | | | |
| Patient Name | | First Middle Last | | | | | |
| Social Security #  \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ | | Gender: | | | Date of Birth (Month/Day/Year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | | |
| Home Address | | Street | | | City State ZIP | | |
| Mailing Address | | Street | | | City State ZIP | | |
| Home Phone: | |  | | | Cell Phone: | | |
| Email Address: | |  | | |  | | |
| Primary Language: | | | | | Interpreter Needed? ⬜ Yes ⬜ No | | |
| Homeless | ⬜ Yes ⬜ No  ⬜ Currently not homeless, was in last 12 months  ⬜ Living with friends/family | | | | ⬜ Living in shelter, shelter name: \_\_\_\_\_\_\_\_\_\_\_  ⬜ Street/Camp/Bridge  ⬜ Transitional housing | | |
| Living with: ⬜ Mother ⬜ Father ⬜ Both Mother and Father ⬜ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Race (check all that apply)  ⬜ Alaskan ⬜ American Indian ⬜ Asian  ⬜ Black ⬜ Native Hawaiian ⬜ Pacific Islander  ⬜ White ⬜ Patient refuses to answer | | | | | Ethnic Group:  ⬜ Hispanic ⬜ Non-Hispanic  ⬜ Not collected/unknown ⬜ Refuse to answer | Veteran?  ⬜ Yes  ⬜ No  ⬜ Refuse to answer | |
| **Do you have a primary care provider? ⬜ Yes ⬜ No If yes, please provide provider name:** | | | | | | | |
| **Would you like this clinic to be your primary care provider? ⬜ Yes ⬜ No** | | | | | | | |
| **Parent/Guardian Information (Minors only)** | | | | | | | |
| Mother’s Name | | | | Phone # | Primary Language: | | Interpreter Needed? ⬜ Yes ⬜ No |
| Father’s Name | | | | Phone # | Primary Language: | | Interpreter Needed? ⬜ Yes ⬜ No |
| Employer | | | Name Phone Type of Work | | | | |
| Emergency Contact | | | Name Phone Relationship | | | | |

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| **\\talus\Common\Administrative Operations\Branding and New Name\Columbia Health Services Logos\Columbia Health Services RGB.jpgInsurance Information of Person Responsible for Payment**  **Registration** | | | | | |
| Legal Name on Insurance Card of  Person Responsible for Payment | | Social Security #  \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ | | Date of Birth  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | Relationship to Patient |
| Insurance Type | ⬜ Medicaid: ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ Medicare: ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ Private Insurance | | | ⬜ No Insurance  ⬜ Work Injury |  |
| Primary Insurance Carrier Name | | Insurance ID# | | | Group # |
| Mailing Address (on card) Street City State ZIP | | | | | Effective from date: |
| Secondary Insurance Carrier Name | | Insurance ID# | | | Group # |
| Mailing Address (on card) Street City State ZIP | | | | | Effective from date: |
| **Please Identify the average monthly income for your household for the sliding scale** | | | $ **# in household** | | |