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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** |