

New Client Registration Form



Date of Birth (Month/Day/Year)

Patient's Preferred Language

Patient Last Name

Patient First Name

Middle Initial

Please provide the following information for the responsible party (Parent/Guardian):

(Who the subscriber is for the insurance)

PRINT Name of parent/guardian/responsible party (if other than client)

Date of Birth (mm/dd/yy)

Address

Apt #

City

State

ZIP

Home or Message Number (circle one)

Cell Number

Relationship to patient (e.g Mother, Father)

Are you the Patient's Legal Guardian?

How may we communicate with you?
(Please select all that apply)

Phone

Mail

E-mail

E-mail address

Multnomah County Health Department requires that we collect the following demographic data. This information is confidential and allows us to continue to provide quality services. Our electronic health record limits us to the gender options below, please mark one. If none fully describe your gender identity, please let your provider know.

Choose one or more of the following for Ethnic Group and/or Race:

Ethnic Group

- Hispanic
- Non-Hispanic
- Unknown

Race

- Asian
- Black
- White
- Unknown
- Alaskan Native
- American Indian
- Native Hawaiian
- Pacific Islander

Gender

- Male
- Female
- Transgender M to F
- Transgender F to M
- Unknown

FINANCIAL INFORMATION (Required):

- I have medical insurance, please bill my medical insurance (please select type and attach card)
 - OHP/Care Oregon/Medicaid
 - Medicare
 - Other _____
- I do not have medical insurance

*Health Care Reform creates expanded access to medical insurance at no cost or tax credits.
To complete an application go online to www.healthcare.gov.*