

NEW CLIENT INFORMATION – Part 1

Last Name: _____ First: _____ Middle Initial: _____
 Date of Birth: _____ Social Security Number (SSN): _____
 Preferred Name: _____

Sex assigned at birth:
 Female Male

Student Cell: _____ Home Phone: _____
Can we contact you at home? Yes No

Address: _____ APT# _____
 City/State: _____ Zip: _____

What school do you attend? _____ Grade: _____

Emergency Contact (Required)

Who is a responsible adult that we can notify in case of emergency: _____
 Relationship: _____ Home Phone: _____
 Cell Phone: _____ Work Phone: _____

Other Contacts

Parent/guardian (first & last name): _____ Relationship: _____
 Home#: _____ Cell#: _____ Work#: _____
 Date of Birth _____ Social Security Number (SSN): _____

Parent/guardian (first & last name): _____ Relationship: _____
 Home#: _____ Cell#: _____ Work#: _____
 Date of Birth _____ Social Security Number (SSN): _____

Step-mother name: _____ Phone#: _____

Step-father name: _____ Phone#: _____

Grandparent name: _____ Phone#: _____

Case Manager name: _____ Phone#: _____

Other - name: _____ Relationship: _____ Phone#: _____

I live with my (check all that apply):

Mother(s) Father(s) Foster Parent(s) Grandparent(s)

Other - Name: _____ Relationship: _____

NEW CLIENT INFORMATION – Part 2

Household Information

Who lives in your home?

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

Where do you usually go for medical care? Doctor: _____

Where do you usually go for dental care? Dentist: _____

Insurance Information

Providing us with your insurance coverage information allows us to bill for services and reduces our need for public funding so we can provide care to as many students as possible. If your insurance doesn't pay for all or part of the cost you are not responsible for any out-of-pocket expenses for services received at a Student Health Center.

Families with no health insurance or who do not provide insurance information are referred for screening to see if they qualify for the Oregon Health Plan or other insurance programs.

We strongly encourage you to apply for this valuable coverage.

I have Medicaid/Oregon Health Plan *Please let us make a copy of your insurance card*

Name of Insurance Company: _____ **Effective date:** _____

Company/Claim Address (including city/state/zip): _____

Phone number: _____ **Policy/ID/Patient number:** _____

Group number: _____

Subscriber (parent/guardian who provides insurance) Name: _____

Date of birth: _____ Social Security Number (SSN): _____

Relationship to student: _____

Is the student covered under more than one policy? Please give us information for all insurance coverage, and let us know which one is first (primary).