



PATIENT REGISTRATION FORM

**West Salem Clinic
West Salem Clinic Dental
Total Health Community Clinic**

PATIENT INFORMATION:				Date:	Acct. No.	Chart No.
Last Name	First Name	MI	Social Security No.	Date of Birth	Marital Status	Male/Female
Street Address			City	State	Zip Code	Home Phone
Mailing Address (if different from above)						
Occupation	Annual Income	Number in Family	Emergency Contact		Phone Number	
Employer Name	Employer Address	City	State	Zip	Work Phone Number	
Responsible Party		Social Security No.	Date of Birth	Phone Number	Relationship	
Employer Name	Employer Address	City	State	Zip	Work Phone Number	

INSURANCE INFORMATION:

Primary Insurance Company	Group No.	ID#	Insurance Phone Number:		
Insured Party	Social Security No.	Date of Birth	Phone Number	Relationship	
Secondary Insurance Company	Group No.	ID#	Insurance Phone Number:		
Insured Party	Social Security No.	Date of Birth	Phone Number	Relationship	

INFORMATION REQUESTED FOR FEDERAL SUPPORT

Race: ___ Asian ___ African American ___ Caucasian ___ Hispanic ___ Native American Other: _____

In the past 24 months have you or another wage earner in your immediate family:

- Been hired to do farm work? Yes NO
- Earned the largest part of your family income from farm work? Yes NO
- Moved temporarily (i.e., established a temporary place to live) in order to do farm work? Yes NO

CONSENT TO TREAT

I, _____, hereby authorize the providers of Northwest Human Services to provide such medical service, including surgery, regular or emergency, as determined to be in the best interest of myself, or of my child or legal charge, if I am a parent or legal guardian. This authorization shall continue and be in full force and effect until revoked in writing.

Patient's Signature

Parent or Legal Guardian if Patient is Under 18

Date

My initials beside the following statements indicate my understanding and consent:

_____ I have been given written information regarding my rights and responsibilities as a patient of NWHS.
_____ I have rights been given written information about Advance Directives.

ASSIGNMENT OF BENEFITS

I hereby authorize Northwest Human Services to furnish the insured's insurance company(ies) all information which said insurance company(ies) may request concerning my present claim. I hereby assign to Northwest Human Services all monies to which I am entitled for expense related to the services performed from time to time, but not to exceed my indebtedness to Northwest Human Services. It is understood that all monies received from the above named insurance company(ies) over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Northwest Human Services for charges not covered by this assignment.

Patient's Signature

Responsible Party's Signature

Date



Name: _____

Date of Birth: _____

Date Completed: _____

Past Medical History:

Habits:

Yes	No	Type	Problem	Habits:	Yes	No	If Yes, Describe & Amount
		Head/Neck		Smoking			
		Neurological		Alcohol			
		Heart		Caffeine			
		Blood Pressure		Beverages			
		Lungs		Street Drugs			
		Breasts		Exercise			
		Stomach/Bowel/Liver		Occupation			
		Uterus/Ovaries		Married			
		Prostate/Impotence		Children			
		Depression/Anxiety					
		Kidney/Bladder					
		Diabetes/Thyroid					
		High Cholesterol					
		Sexually Transmitted Dis.					
		Abnormal PAP					
		Cancer					
		Other					

Surgery

Previous Pregnancies

Year	Operation	Year	Vaginal	Caesarean	Abortion	Sex	Wt.	Place of Delivery	Complications

Family History:

Any Family Members with the following Diseases?

Relation	Age	Present Health	Age of Death	Cause of Death	Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brother					Cancer	
					Drug Use	
					Diabetes	
Sister					Heart Disease, Stroke	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Reviewed by:					
Date					
Reviewed by:					
Date					
Reviewed by:					
Date					
Reviewed by:					
Date					



WSC/THCC

PATIENT LABEL HERE

Patient Demographics
Sliding Fee/Income Verification

As a recipient of Federal Funding, Northwest Human Services is required to gather and report demographic information on patients served. This information will be used for reporting on our patient population as a whole and will not be disclosed on an individual basis to other entities or agencies without your prior written consent.

ETHNICITY:

- ASIAN WHITE HISPANIC/LATINO PACIFIC ISLANDER
AMERICAN INDIAN/ALASKAN NATIVE BLACK OR AFRICAN AMERICAN

HOUSING STATUS:

- DOUBLING UP SINGLE FAMILY DWELLING HOMELESS

PRIMARY LANGUAGE:

- ENGLISH SPANISH VIETNAMESE
RUSSIAN OTHER

Migrant/Seasonal /Other:

- MIGRANT: I, or supporting members of my family, have worked in agriculture on a seasonal basis and have established a temporary home for the purpose of such employment in the past 24 months.
SEASONAL: I, or supporting members of my family have worked in agriculture on a seasonal basis in the past 24 months but have not established a temporary home for such a purpose.*
OTHER: I do not, and none of my family members work seasonally in agriculture.

* Agriculture includes any farming operations, warehouses, processing plants, and mills. It is defined as farming of the land in all its branches, including cultivation, tillage, growing, harvesting, preparation and on-site processing for market storage.

FAMILY SIZE AND ANNUAL FAMILY INCOME:

Family Size: _____

Annual Family Income: _____

GUARANTOR NAME

DATE OF BIRTH

Patient/Parent/Guardian Date:

Witness

COMPREHENSIVE LEARNING (NEEDS) ASSESSMENT

1. **Do you have difficulty reading?**

Yes NO

(If yes, have staff help you fill out form.)

2. **What languages are you most comfortable reading?**

English Spanish Russian Other _____

3. **What languages are you most comfortable speaking?**

English Spanish Russian ASL Other _____

4. **Do you have difficulty hearing?**

Yes NO

5. **Do you wear glasses or contacts?**

Yes NO

6. **Which method helps you learn the easiest?**

- Reading Materials (Pamphlets, handouts, etc.)
 Watching Videos
 Talking One on One
 Other:

7. **Would you like to learn more about health issues?** (Please select below)

Yes NO If yes, please describe: _____

8. **Are there barriers that prevent you from getting the health care information that you need?**

Please Explain: _____

9. **Are there any special preferences (cultural or religious) you would like us to consider when delivering treatment?**

Yes NO If yes, please explain: _____

Patient Signature

Date:

Statement of Patient Responsibilities

Our Patients Have the Responsibility To:

Provide Information

- Provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters relating to their health.
- Assist in obtaining information from other providers through a release of information.
- Report perceived risks in their care and unexpected changes in their condition.
- Provide feedback about service needs and expectations.
- Let us know of changes in address, phone number, or other requested information

Participate in Treatment

- Participate in development of mutually agreed-upon treatment plans.
- Follow the care, treatment, and service plan developed.
- Ask questions when unable to understand their care, treatment and services or what they are expected to do.
- Express concerns about the proposed care plan or course of care, treatment and services.
- Be informed of the consequences of care, treatment, and service alternatives if changes are not recommended.

Follow Rules and Regulations

- Follow NWHS guidelines.
- Arrive on time for appointments.
- Comply with signed patient contracts

Show Respect and Consideration

- Be considerate of staff, patients and agency property.
- Provide at least 24-hours notice when canceling appointments.

Meet Financial Obligations

- Follow all insurance company guidelines about how to access services
- Pay for services not covered by insurance.
- Take financial responsibility for payment for all charges including:
 - Bring in your insurance card each time you come to the clinic if you are insured.
 - Provide information about all insurance that is available for treatment.
 - Pay appropriate charges at the time of your visit.
 - Bring in documentation of eligibility for a discount in a timely manner if you are uninsured.
 - Bring in eligibility information for the Oregon Health Plan in a timely manner, if requested by the clinic's Enrollment and Eligibility Specialist.
 - Contact the Billing Department immediately to make payment arrangements if you have an outstanding bill.

Statement of Patient Rights

Our Patients have the Right to:

Service

- Services regardless of your race, sex, religion, age, ethnic background, linguistic preference, education, social class, economic status, sexual orientation, or handicap.
- Services provided in a private, protected and humane service environment to meet your individual needs.

Respect

- Receive care that respects and is sensitive to your cultural, psychosocial, and personal values and beliefs.
- A copy of any rules or regulations related to the conduct of patients.
- To expect that our employees be sensitive to your needs and feelings.

Privacy and Confidentiality

- To know that your records and communications are confidential to the extent provided by law.
- Access, request changes to, and receive a list of disclosures regarding his or her own health information as permitted by law.
- Confidentiality, privacy, and protection of personal dignity during examination and treatment.

Continuum of Care

- Referral to other services and agencies that is necessary for continuity of care.

Information and Treatment

- Know your diagnosis, treatment, prognosis, and possible consequences of treatment.
- Be informed of and involved in decisions about your care, treatment and services that would enable you to give informed consent.
- Refuse any suggested treatment, and the right to discontinue treatment at any time.
- Know the name and qualifications of anyone who is involved in your care.
- Have a guardian or surrogate decision maker, as allowed by law, when you cannot make decisions about your care, treatment, and services.
- Have your guardian, family, with your permission or the surrogate decision maker, to be involved in care, treatment, and service decisions.
- Obtain, question, and discuss a full accounting of charges for your care regardless of the source of payment.

Communication

- Have all communications in a language that you can clearly understand.

Complaints

- Be involved in resolving issues about your care, treatment, and services.
- File or request assistance in filing a complaint about services or the treatment being provided.