NEHALEM BAY HEALTH CENTER REGISTRATION FORM

PATIENT INFORMATION

Received by: _____
Entered by: _____

NAME (FIRST, MIDDLE, LAST): _____ **PREFERRED NAME:** _____

HAVE YOU BEEN KNOW BY ANY OTHER NAMES IN THE PAST (I.E. MAIDEN NAME, MARRIED NAME, ALIASES)?

☐ **YES** ☐ **NO** **IF YES, PLEASE LIST THOSE NAMES HERE:** _____

SSN: _____ **GENDER:** _____ **BIRTHDATE:** _____

MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHYSICAL ADDRESS: _____

CITY, STATE, ZIP CODE: _____

HOME PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE?** ☐ **Y** ☐ **N**

CELL PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE?** ☐ **Y** ☐ **N**

WORK PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE?** ☐ **Y** ☐ **N**

EMAIL ADDRESS: _____

HAVE YOU EVER SERVED IN THE ARMED SERVICES? ☐ **Y** ☐ **N**

EMPLOYMENT STATUS (CHECK ONE): ☐ FULL-TIME ☐ PART-TIME ☐ UNEMPLOYED ☐ RETIRED ☐ CHILD

CURRENT EMPLOYER (IF APPLICABLE): _____

WOULD YOU LIKE TO RECEIVE INFORMATION ON OUR UPCOMING CLASSES, EVENTS, NEWS VIA EMAIL? ☐ **Y** ☐ **N**

How did you hear about Nehalem Bay Health Center?

_____

Name: _____ DOB: _____ Date: _____

INSURANCE

DO YOU HAVE INSURANCE? ☐ **Y** ☐ **N**

NAME OF PRIMARY MEDICAL INSURANCE: _____ **EFFECTIVE DATE:** _____

ID # _____ **GROUP #** _____ **SUBSCRIBER'S NAME:** _____

RELATIONSHIP TO SUBSCRIBER: _____ **SUBSCRIBER'S DATE OF BIRTH:** _____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: _____

NAME OF SECONDARY MEDICAL INSURANCE: _____ **EFFECTIVE DATE:** _____

ID # _____ **GROUP #** _____ **SUBSCRIBER'S NAME:** _____

RELATIONSHIP TO SUBSCRIBER: _____ **SUBSCRIBER'S DATE OF BIRTH:** _____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: _____

GUARANTOR ACCOUNT / RESPONSIBLE PARTY FOR PAYMENT (IF DIFFERENT FROM PATIENT)

NAME (FIRST, MIDDLE, LAST): _____

SSN: _____ **GENDER:** _____ **BIRTHDATE:** _____

MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

EMPLOYMENT STATUS (CHECK ONE): ☐ FULL-TIME ☐ PART-TIME ☐ UNEMPLOYED ☐ RETIRED ☐ N/A

CURRENT EMPLOYER (IF APPLICABLE): _____

HOME PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE?** ☐ **Y** ☐ **N**

CELL PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE?** ☐ **Y** ☐ **N**

WORK PHONE: _____ **MAY WE LEAVE A DETAILED MESSAGE?** ☐ **Y** ☐ **N**

Name: _____ DOB: _____ Date: _____

As a Federally Qualified Health Center, we are required to collect and update this information annually.

Please complete the information below.

EMERGENCY CONTACT

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP TO YOU:** _____

HOME PHONE: _____ **CELL PHONE:** _____

ANNUAL HOUSEHOLD INCOME

FAMILY SIZE: _____

YEARLY INCOME (CHECK RANGE): ☐ $0 ☐ $1,000-$10,000 ☐ $10,001-$20,000 ☐ $20,001-$30,000

☐ $30,001-$40,000 ☐ $40,001-$50,000 ☐ $50,001-$60,000 ☐ $60,001-$70,000

☐ $70,001-$80,000 ☐ $80,001-$90,000 ☐ $90,001-$98,500

ADDITIONAL INFORMATION

PREFERRED LANGUAGE: _____ **DO YOU NEED AN INTERPRETER?** ☐ **Y** ☐ **N**

VISUALLY IMPAIRED? ☐ **Y** ☐ **N** **HARD OF HEARING?** ☐ **Y** ☐ **N**

DO YOU CONSIDER YOURSELF HOMELESS? ☐ **Y** ☐ **N** **ARE YOU A MIGRANT WORKER?** ☐ **Y** ☐ **N**

ETHNICITY (CHECK ALL THAT APPLY):

☐ NON-HISPANIC ☐ MEXICAN, MEXICAN AMERICAN, CHICANO/A ☐ CUBAN ☐ PUERTO RICAN

☐ ANOTHER HISPANIC, LATINO/A OR SPANISH ORIGIN ☐ UNKNOWN ☐ DECLINE TO ANSWER

RACE/HERITAGE (CHECK ALL THAT APPLY):

☐ ALASKAN NATIVE ☐ AMERICAN INDIAN ☐ ASIAN INDIAN ☐ BLACK/AFRICAN AMERICAN ☐ CHINESE

☐ FILIPINO ☐ GUAMANIAN OR CHAMORRO ☐ JAPANESE ☐ KOREAN ☐ NATIVE HAWAIIAN ☐ OTHER ASIAN

☐ OTHER PACIFIC ISLANDER ☐ SAMOAN ☐ VIETNAMESE ☐ WHITE ☐ UNKNOWN ☐ DECLINE TO ANSWER

Name: _____ DOB: _____ Date: _____

NEHALEM BAY
HEALTH CENTER & PHARMACY
COMPASSIONATE COMMUNITY CARE

Received by: _____
Entered by: _____

230 Rowe Street | PO Box 176 | Wheeler, OR 97147 | 1-800-368-5182 | Fax: 1-844-712-3001 | nehalembayhealth.org

Release of Verbal Medical Information

Patient Name: _____ DOB: _____

Due to patient confidentiality laws, Nehalem Bay Health Center does not verbally release any information regarding our patients to anyone other than the patient, or any physician to whom Nehalem Bay Health Center has referred you. At times, patients may wish to have information regarding their health condition(s), lab reports, medication, appointment times, etc. discussed with other individuals such as family members or caretakers. If this applies to you, please indicate below any person with whom you would like us to share information regarding your care at Nehalem Bay Health Center.

Please **initial** what you would like shared with the person(s) listed below:

_____ I authorize Nehalem Bay Health Center to verbally release information regarding my medical care, including mental health and substance use.

_____ I authorize Nehalem Bay Health Center to verbally release information regarding my financial record.

_____ I authorize Nehalem Bay Health Center to allow appointments to be scheduled on my behalf.

_____ **I Decline** to have any information verbally released by Nehalem Bay Health Center.

Note: Any updates to this information, i.e. removing authorizations, will need to be made by completing a new Release of Information.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____

Name: _____ DOB: _____ Date: _____

NEHALEM BAY
HEALTH CENTER & PHARMACY
COMPASSIONATE COMMUNITY CARE

Received by: _____
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CONSENT TO TREAT & AUTHORIZATION FOR RELEASE OF BILLING INFORMATION

Please read the following completely and sign below. Services may be withheld if not signed.

I consent to health care and treatments (for myself and/or for the person for whom I am guardian) as may be deemed necessary, advisable and ordered by the healthcare provider(s) at Nehalem Bay Health Center. This may include, but are not limited to laboratory procedures, x-ray examination, mental health and substance abuse services.

I hereby authorize Nehalem Bay Health Center to release to a third-party payer any medical or psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such a third-party for its use in determining a claim for payment for such treatment and/or diagnosis.

I agree to pay for all services provided by Nehalem Bay Health Center. I understand that I am financially responsible for the fees for the services and procedures rendered and/or any other related fees. I hereby authorize payment of medical benefits directly to Nehalem Bay Health Center herein specified and otherwise payable to me for their service(s) as described, but not to exceed the reasonable and customary charges for these services.

I permit a copy of this authorization and assignment to be used in place of the original that is on file at the healthcare provider's office. This assignment will remain in effect until revoked by me in writing.

I have read and I understand the above statement and my financial responsibilities.

PATIENT/GUARDIAN/PATIENT REPRESENTATIVE

PRINT NAME: _____

SIGNATURE: _____

DATE: _____