

Pendleton Primary Care Clinic

Patient Registration Form

Date: _____

PATIENT INFORMATION

First Name: _____ Middle: _____ Last Name: _____

Date of Birth: _____ Sex: Male Female Social Security #: _____

Gender Identity: Male Female Transgender Male Transgender Female Other: _____ Decline

Sexual Orientation: Straight/Heterosexual Gay/Lesbian/Homosexual Bisexual Other: _____ Decline

Race: American Indian/Alaskan Native Asian Black/African American Pacific Islander/Native Hawaiian

White Unknown Decline

Preferred Language: _____ **Ethnicity:** Non-Hispanic/Latino Hispanic/Latino Unknown Decline

Cell Phone: _____ Other Phone: _____ Email: _____

How would you prefer to be contacted? Text Phone Email

Mailing Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ **Relationship to patient:** _____ **Phone #:** _____

Would you like to file a POLST (physician orders for life sustaining treatment) or an Advanced Directive with the Oregon Registry? Yes No

RESPONSIBLE PARTY (IF DIFFERENT THAN ABOVE)

First Name: _____ Last Name: _____ Date of Birth: _____

Relationship to Patient: _____ SSN: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Group #: _____ ID #: _____

Subscriber Name: _____ Relationship to Patient: _____ **Subscriber DOB:** _____

Secondary Insurance Company: _____ Group #: _____ ID #: _____

Subscriber Name: _____ Relationship to Patient: _____ **Subscriber DOB:** _____

Preferred Pharmacy: Pendleton Walmart Pendleton Rite Aid Pendleton Safeway Other: _____

How did you hear about us? Friend Google Search Facebook Our Website Radio Newspaper

Insurance Company Other Online Source: _____ Other: _____