❒ Public Health
2370 Gable Rd.
St. Helens, OR 97051
(503) 397-4651

❒ Vernonia Health
1005 Cougar Street
Vernonia, OR 97064
(503) 429-0622

❒ Spencer Health
1000 Missouri Ave.
Vernonia, OR 97064
(503) 429-1399

❒ Rainier SBHC
28168 Old Rainier Rd.
Rainier, OR 97048
(503) 556-2178

❒ Sacagawea
1060 Eisenschmidt Ln.
St. Helens, OR 97051
(503) 366-7645

Registration Form

Patient Information

Patient Name — First — Middle — Last

Social Security # _____-_____-_____ | Gender: | Date of Birth (Month/Day/Year) ____/____/____

Home Address — Street — City — State — ZIP

Mailing Address — Street — City — State — ZIP

Home Phone: | Cell Phone:

Email Address:

Primary Language: | Interpreter Needed? ☐ Yes ☐ No

Homeless
☐ Yes ☐ No
☐ Currently not homeless, was in last 12 months
☐ Living with friends/family
☐ Living in shelter, shelter name: _____
☐ Street/Camp/Bridge
☐ Transitional housing

Living with: ☐ Mother ☐ Father ☐ Both Mother and Father ☐ Other _____

Race (check all that apply)
☐ Alaskan ☐ American Indian ☐ Asian
☐ Black ☐ Native Hawaiian ☐ Pacific Islander
☐ White ☐ Patient refuses to answer

Ethnic Group:
☐ Hispanic ☐ Non-Hispanic
☐ Not collected/unknown
☐ Refuse to answer

Veteran?
☐ Yes
☐ No
☐ Refuse to answer

Do you have a primary care provider? ☐ Yes ☐ No If yes, please provide provider name:

Would you like this clinic to be your primary care provider? ☐ Yes ☐ No

Parent/Guardian Information (Minors only)

Mother's Name	Phone #	Primary Language:	Interpreter Needed? ☐ Yes ☐ No
Father's Name	Phone #	Primary Language:	Interpreter Needed? ☐ Yes ☐ No

Employer — Name — Phone — Type of Work

Emergency Contact — Name — Phone — Relationship

Insurance Information of Person Responsible for Payment

Legal Name on Insurance Card of Person Responsible for Payment | Social Security # _____-_____-_____ | Date of Birth ____/____/____ | Relationship to Patient

Insurance Type
☐ Medicaid: ID#_____
☐ Medicare: ID# _____
☐ Private Insurance
☐ No Insurance
☐ Work Injury

Primary Insurance Carrier Name	Insurance ID#	Group #
Mailing Address (on card) Street City State ZIP		Effective from date:
Secondary Insurance Carrier Name	Insurance ID#	Group #
Mailing Address (on card) Street City State ZIP		Effective from date:

Please Identify the average monthly income for your household for the sliding scale $ **# in household**