Patient Registration

Waterfall Community Health Center is a Federally Qualified Health Center and receives federal funding pursuant to Section 330 of the Public Health Service Act. We are required to collect information about age, gender, race, sexual orientation, income, and family size for statistical purposes only. No individual information is submitted.

Waterfall Community Health Center

Please choose what specialty of care you would like, select all that apply:

☐ **Primary Care** ☐ **Mental Health** ☐ **Women's Health** ☐ **Social Health**

PATIENT INFORMATION

First Name: | **Middle:** | **Last Name:**

Preferred Name (if different) | **Social Security No (SSN):**

Birthdate: MO/DAY/YR

Birth Sex: ☐ Female ☐ Male

I Identify as (gender identity): ☐ Male ☐ Female ☐ Other ☐ Transgender Male: Female-to-Male ☐ Transgender Female: Male-to-Female ☐ Choose Not to Disclose

Mailing Address:

City: | **State:** | **Zip:**

Sexual Orientation: ☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose

Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated

Email: ☐ I do not have email

Home Phone: | **Cell Phone:** | **Work Phone:**

Household Income: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually **Family Size** (include self):

Reduced Fees: Are you interested in applying for our reduced fees (even if you are insured)? ☐ Yes (proof of income will be requested) ☐ No Verified ____

Race (choose all that apply): ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Other ☐ Choose Not to Disclose

Ethnicity (choose one): ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Choose Not to Disclose

Preferred Language: ☐ English ☐ Spanish ☐ Other (specify):

Living Status: ☐ Own Home/Rent ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Unknown ☐ Other: ☐ Public Housing

Employment Status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Retired

Employer (if applicable): ☐ US Citizen

Farmworkers:
Does anyone in your household work in the fields or food processing plants? ☐ Yes ☐ No ☐ Seasonal
If yes, did he/she work in the fields or food processing plants away from this area in the past 24 months? ☐ Yes ☐ No

Veteran's Status: ☐ Veteran ☐ Non-Veteran

RESPONSIBLE PARTY

Primary Responsible Party (Legal and/or Financial)

First Name: | **Middle:** | **Last Name:** | **Birthdate:** | **Address** (if different): | **Phone:**

Employer: | **Employer Phone::** | **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Responsible Party (Legal and/or Financial)

First Name: | **Middle:** | **Last Name:** | **Birthdate:** | **Address** (if different): | **Phone:**

Employer: | **Employer Phone::** | **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other

INSURANCE INFORMATION *(PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)*

Primary Medical Insurance	Secondary Medical Insurance	Dental Insurance
Name of Insurance:	**Name of Insurance:**	**Name of Insurance:**
Policy Number:	**Policy Number:**	**Policy Number:**
Group Number:	**Group Number:**	**Group Number:**
Subscribers Name: **Birthdate:**	**Subscribers Name:** **Birthdate:**	**Subscribers Name:** **Birthdate:**
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Parent ☐ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative: | **Relationship to Patient:** | **Phone Number:** | **Alternate Phone Number:**

Mission Statement: "To promote access to quality integrated health services that meet the needs of individuals with barriers to care on the Southern Oregon Coast"