21810 Willamette Drive, Suite 200
West Linn, OR 97068
Phone: (503) 994-4353
Fax: (833) 975-0942

HOLY FAMILY CATHOLIC CLINIC

PATIENT REGISTRATION FORM

Date: _____

How did you hear about us?

☐ Church ☐ Family/Friend ☐ Brochure/Poster ☐ Website ☐ Radio ☐ Newspaper

☐ Social Media (Please Specify: _____) ☐ Other: _____

NAME: _____ SSN: _____-_____-_____ Sex: ☐ M ☐ F
Last First Middle

Date of Birth (DOB): _____ Age: _____ Preferred Name (Nickname): _____

Home Address: _____ Home Phone: (_____) _____-_____

City: _____ State: _____ ZIP: _____ Cell Phone (_____) _____-_____

Email: _____ Preferred Language: _____ Race/Ethnicity: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

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Emergency Contact: _____ _____ (____) _____-_____
Name Relationship Phone Number

Responsible Party (Guarantor) Information:

_____ _____ ____/_____/_____ (____) _____-_____
Name Relationship DOB Phone Number

By signing this form, I recognize that the information above is complete and accurate to my knowledge. I understand that I have the right to refuse completing certain portions of this form without my enrollment being compromised. I recognize that this form will be used within the boundaries of the Notice of Privacy Practices of Holy Family Catholic Clinic, P.S., which I can request a copy of at any time.

_____
Print Patient Name

× _____ _____
Signature of patient or legal guardian/representative Date