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

HOLY FAMILY
CATHOLIC CLINIC

PATIENT REGISTRATION FORM

NAME**:** ____ **SSN**: ______-_____-_______
Last First Middle

Date of Birth: _________________ Preferred Name (Nickname): ____________________ Sex: M ☐ F ☐

Home Address: ____ Home Phone: (______) ______-________

City: ____________________________ State: _______ ZIP: ______________ Cell Phone: (______) ______-________

Email: ____________________________ Preferred Language: ________________ Race: _________________________

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

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

Responsible Party (Guarantor) Information:

_____________________________________ _____________________ ____/_____/________ (____) _____-_______
Name Relationship DOB Phone Number

How did you hear about us?

☐ Church: ____________________ ☐ Family/Friend:_______________ ☐ Brochure/Poster ☐ Website
☐ Radio ☐ Newspaper ☐ Social Media: _______________ ☐ Other: ____________________

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.

X____ _______________________
Signature of patient or legal guardian/representative Date