21810 Willamette Drive, Suite 200
West Linn, OR 97068

HOLY FAMILY CATHOLIC CLINIC

1829 NW Kings Blvd.
Corvallis, OR 97330

PATIENT REGISTRATION FORM

Patient Name: _____ Social Security #: _____-_____-_____
Last First MI

Date of Birth: _____/_____/_____ Preferred Name (Nickname): _____ Sex: M ☐ F ☐

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

City: _____ State: _____ Zip: _____ Cell Phone #: (_____) _____-_____
OK to Text? ❑ Yes ❑ No

Email: _____

Marital Status:
- ❑ Married
- ❑ Single
- ❑ Divorced
- ❑ Separated
- ❑ Widowed
- ❑ Partner

Language:
- ❑ English
- ❑ Spanish
- ❑ Chinese
- ❑ Arabic
- ❑ Other: _____

Race:
- ❑ White
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Middle Eastern or North African
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Other _____
- ❑ Patient refused

Ethnicity:
- ❑ Hispanic or Latino/Spanish
- ❑ Not Hispanic or Latino
- ❑ Patient refused

Responsible Party (Guarantor) Information

_____ _____ (_____) _____-_____
Name Relationship to patient Phone Number

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

How did you hear about us? _____

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