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): _____ Gender: M ☐ F ☐

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

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

Email: _____

PCP (if other than HFCC): _____ Office Location: _____

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

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

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

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

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

How did you hear about us? _____

Check box if you wish to *opt out* of our mailing list ❑

Insurance Information

IF card(s) not taken at front desk

Insurance Plan: _____ ID #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Relationship to Patient: _____

Secondary Insurance (if applicable): _____ ID #: _____

Financial Responsible Party (if other than patient) Name & DOB: _____

X_____ _____
Signature of patient or legal guardian/representative Date

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 to complete 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.