

WEST LINN FAMILY HEALTH CENTER, P.C.

18380 WILLAMETTE DRIVE, SUITE 202 - WEST LINN, OREGON 97068-1718 - PHONE (503) 635-8384 - FAX (503) 636-6475

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PATIENT INFORMATION				
PATIENT NAME:	LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX
MARITAL STATUS				
PRESENT ADDRESS			CITY	STATE
ZIP				
BIRTHDATE	AGE	SOCIAL SECURITY NUMBER		HOME PHONE
EMAIL				CELL PHONE
EMPLOYER		OCCUPATION		WORK PHONE
RELIGIOUS PREFERENCE	RACE <i>(please check appropriate box[s])</i>			ETHNICITY <i>(please check appropriate box[s])</i>
PREFERRED LANGUAGE	<input type="radio"/> American Indian or Alaska	<input type="radio"/> Asian	<input type="radio"/> Hispanic	<input type="radio"/> Hispanic or Latino
	<input type="radio"/> Native Hawaiian	<input type="radio"/> Black or African American	<input type="radio"/> Other race	<input type="radio"/> Non Hispanic or Latino
	<input type="radio"/> White	<input type="radio"/> Other Pacific Islander	<input type="radio"/> Unreported / Refuse to Report	<input type="radio"/> Refuse to report
PREVIOUS PRIMARY CARE DOCTOR				
HOW DID YOU HEAR ABOUT US?		HAVE ANY FAMILY MEMBERS BEEN SEEN HERE BEFORE?		TODAY'S DATE

SPOUSE ~OR~ PARENT(S) INFORMATION			
SPOUSE'S NAME <i>(if applicable)</i>		FATHER'S NAME <i>(if applicable)</i>	
MOTHER'S NAME <i>(if applicable)</i>			
SPOUSE'S EMPLOYER <i>(if applicable)</i>	OCCUPATION	WORK PHONE	SOCIAL SECURITY NUMBER
FATHER'S EMPLOYER <i>(if applicable)</i>	OCCUPATION	WORK PHONE	SOCIAL SECURITY NUMBER
MOTHER'S EMPLOYER <i>(if applicable)</i>	OCCUPATION	WORK PHONE	SOCIAL SECURITY NUMBER

IN CASE OF EMERGENCY		
NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU WHO WE COULD REACH IN CASE OF AN EMERGENCY		
NAME:	RELATION:	PHONE:

MEDICAL INSURANCE INFORMATION	
<i>(needs to be filled out even if a copy of the card was taken)</i>	
PRIMARY INSURANCE COMPANY	AMOUNT OF CO-PAY OR DEDUCTIBLE <i>(CIRCLE ONE)</i>
INSURANCE ADDRESS	
NAME OF PERSON WHO CARRIES THE INSURANCE <i>(mandatory)</i>	SOCIAL SECURITY #
DATE OF BIRTH	RELATIONSHIP
INSURANCE ID #	INSURANCE GROUP #
SECONDARY INSURANCE COMPANY	AMOUNT OF CO-PAY OR DEDUCTIBLE <i>(CIRCLE ONE)</i>
INSURANCE ADDRESS	
NAME OF PERSON WHO CARRIES THE INSURANCE <i>(mandatory)</i>	SOCIAL SECURITY #
DATE OF BIRTH	RELATIONSHIP
INSURANCE ID #	INSURANCE GROUP #