West Linn Family Health Center, P.C.

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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 for the PATIENT PORTAL	CELL PHONE

EMPLOYER	OCCUPATION	WORK PHONE

RELIGIOUS PREFERENCE	RACE *(please check appropriate box[s])*		ETHNICITY *(please check appropriate box[s])*
	○ American Indian or Alaska ○ Asian ○ Native Hawaiian ○ Black or African American ○ White	○ Hispanic ○ Other race_____ ○ Other Pacific Islander ○ Unreported / Refuse to Report	○ Hispanic or Latino ○ Non-Hispanic or Latino ○ Refuse to report
PREFERRED LANGUAGE			

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 *(if applicable)*	FATHER'S NAME *(if applicable)*	MOTHER'S NAME *(if applicable)*

SPOUSE'S EMPLOYER *(if applicable)*	OCCUPATION	WORK PHONE	SOCIAL SECURITY NUMBER
FATHER'S EMPLOYER *(if applicable)*	OCCUPATION	WORK PHONE	SOCIAL SECURITY NUMBER
MOTHER'S EMPLOYER *(if applicable)*	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

(needs to be filled out even if a copy of the card was taken)

PRIMARY INSURANCE COMPANY	AMOUNT OF CO-PAY OR DEDUCTIBLE *(CIRCLE ONE)*

INSURANCE ADDRESS

NAME OF PERSON WHO CARRIES THE INSURANCE *(if not patient)*	SOCIAL SECURITY #	**DATE OF BIRTH**	RELATIONSHIP

INSURANCE ID #	INSURANCE GROUP #

SECONDARY INSURANCE COMPANY	AMOUNT OF CO-PAY OR DEDUCTIBLE *(CIRCLE ONE)*

INSURANCE ADDRESS			
NAME OF PERSON WHO CARRIES THE INSURANCE *(mandatory)*	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP
INSURANCE ID #			INSURANCE GROUP #

Updated 05-25-17