SBHC Patient Registration

School:_____ **Grade:**_____ **Date:**_____

Birth / Legal Name – *Do not use nicknames*:

Last Name:_____

First Name:_____

Middle Name:_____

Address:_____

_____

City:_____ State: OR Zip:_____

Phone: ☐ Home_____ ☐ Cell_____

How can we get a message to you?

☐ Call me at home ☐ Call me on my cell

☐ Call _____ @ _____

☐ Call _____ @ _____

Date of Birth:_____

Social Security #:_____

Other ID #:_____

Sex: ☐ Female ☐ Male

Race: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Not Collected / Unknown

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Language: ☐ English ☐ Spanish ☐ Other_____

Interpreter Needed: ☐ Yes ☐ No

Parent/Legal Guardian:

Name:_____

How are you related?_____

Address:_____

_____

City:_____ State: OR Zip:_____

Phone: ☐ Home_____ ☐ Cell_____

☐ Work_____

Emergency Contact:

Name:_____

How are you related?_____

Phone: ☐ Home_____ ☐ Cell_____

Name:_____

How are you related?_____

Phone: ☐ Home_____ ☐ Cell_____

Homeless Status:

☐ Currently not Homeless, was in last 12 months

☐ Not Homeless ☐ At Risk for Homeless

☐ Homeless, Unknown Shelter ☐ Living in Shelter

☐ Living with Others ☐ Street, Camp, Bridge

☐ Transitional Housing

Migrant Seasonal Farm Worker (MSFW) Status:

☐ Migrant ☐ Seasonal ☐ Neither

Do you have a doctor/healthcare provider? ☐ Yes ☐ No

If yes, who?_____

Do you have a dentist? ☐ Yes ☐ No

If yes, who?_____

Do you have an eye doctor? ☐ Yes ☐ No

If yes, who?_____

Clackamas Health Centers
School Based Health Center

SBHC Patient Registration

Shred after data entry into Epic

Name:_____

DOB:_____

MRN:_____