Community Health Centers OF BENTON & LINN COUNTIES | Benton County

Patient label

Registration Form

Demographics

Last name:	First:	Middle:
Preferred name:	Name at birth or other names:	
Sex (legal): ☐ Male ☐ Female	☐ Nonbinary ☐ X	
Gender Identity: ☐ Male ☐ Female	☐ M to F ☐ F to M ☐ Other:_____	
Birth date: (*month/date/year*)	Social Security Number:	
Street address:		
City:	State:	ZIP Code:
Mailing address: *(if different from your home address)*		
City:	State:	ZIP Code:
Cell Phone:	Work Phone:	
Home Phone:	Other:	

Do we need to contact you at a different mailing address, phone number, or through an alternate method for confidential issues? ☐ No ☐ Yes, _____

Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Single ☐ Widowed ☐ Other: _____

What is your primary language? _____ | Do you need an interpreter? ☐ Yes ☐ No

Ethnicity:

☐ Cuban
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Another Hispanic Latino/a or Spanish Origin
☐ Multiple Hispanic, Latino/a, or Spanish Origins
☐ Non-Hispanic or Latino/a
☐ Patient Refused
☐ Unknown

Race: *(mark all that apply)*

☐ Alaskan Native
☐ American Indian
☐ Asia Indian
☐ Black/African American
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Samoan
☐ Vietnamese
☐ White
☐ Patient Refused
☐ Unknown

Emergency Contact

Name:	Relationship:
Phone:	Alternate Phone:
Legal Guardian? ☐ Yes ☐ No	

Guarantor (person responsible for payment)

Last name:	First:	Middle:
Last Name at Birth:	Date of Birth: (*month/date/year*)	
Billing Address:		
City:	State:	ZIP Code:
Relationship:		

Benton County OREGON

Name _____

Client # _____ DOB _____

Income Verification for Sliding Fee Discount

Client Name: _____ Client Birth Date: _____
Last First Middle Month/Day/Year

☐ Check here if guarantor is same as client

Guarantor: _____ Date of Birth: _____
Last First Middle Month/Day/Year

Are you employed? ☐ Yes ☐ No

Housing: ☐ own ☐ rent ☐ other - please explain: _____

Monthly Income (List source of monthly income BEFORE taxes and for all household members). If your income status has changed at the time of your next appointment, you are responsible to inform the front desk.

Income Source	Amount
Client Wages	
Spouse / Partner Wages	
Parent / Guardian Wages	
General Assistance - or AFS / AFDC / TANF / Cash Assistance / Food Stamps	
Worker's Comp. / Unemployment	
Housing Assistance (Amount HUD Pays)	
Education Grants / Loans	
Disability Income / Supplemental Security Income / SSI	
Income Pension/Veteran/Retirement	
Income Alimony / Child Support	
Income Dividend/Interest Invest.	
Other Source (explain)	
Total Monthly Income	
Total Annual Income (x 12 months)	$

How many people (in each age group) live on this income and in this home?
Age 0 – 5 _____ Age 6 – 17 _____ Age 18 – 64 _____ Age 65+ _____

I accept the above conditions and agree that information provided is true and correct to the best of my knowledge.

_____ _____
Signature Date

FOR OFFICE USE ONLY DISCOUNT % _____ INITIALS: _____ TERM _____ _____
Start Finish

Community Health Centers
OF BENTON & LINN COUNTIES

Patient label

Community Health Centers of Benton and Linn Counties is able to help our patients offset the cost of health services due to grant support from the government. As a result we are required to gather income and housing information for each of our patients. We realize this is very personal information and we will continue to protect your confidentiality with this information as well as with your personal health information.

Employment Information

Have you or anyone else in your household worked in any of the following industries during the last two years? Please check all that apply:
☐ Orchards
☐ Packing house (fruits, vegetables, gift boxes)
☐ Reforestation / tree planting
☐ Vineyards
☐ Crops / harvesting (fruit, vegetables, flowers, trees, mushrooms, etc.)
If you checked any of the above boxes, did your work ever require your family to move? ☐ Yes ☐ No
Have you been a member of the armed forces? ☐ Yes ☐ No
Employer(s) *(optional)*:

Housing Information

Are you and your family members living in someone else's household? ☐ Yes ☐ No
In the past 24 months, have you and your family been forced to move into a temporary situation because of housing costs? ☐ Yes ☐ No
In the past 24 months, have you or someone in your household lived in one of the following: ☐ Shelter ☐ Transitional housing ☐ Camp or street

Insurance Information

Do you have health insurance? ☐ Yes ☐ No			
☐ I am uninsured or have insurance with a very high deductible and would like to apply for the sliding fee scale to help cover the cost of my visits. (You may be asked to provide verification of your income by providing check stubs or income tax documents.)			
Name of Primary Insurance:			
Insurance Mailing Address:			
City:	State:	ZIP code:	Phone:
Name of Policy Holder:		Relationship to Client:	
Mailing Address:		Phone:	
Insurance ID:		Group #:	
Do you have additional insurance? ☐ Yes ☐ No			

Oregon Department of Human Services

Race, Ethnicity, Language, and Disability (REALD)

Oregon Health Authority

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Please contact _____ at _____

Today's Date: _____ Medical record number (*if applicable*): _____

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

_____

2. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black and African American
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories
- ☐ Other *(please list)*
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?
- ☐ Yes. Please circle your primary racial or ethnic identity above.
- ☐ I do not have just one primary racial or ethnic identity.
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one category above.
- ☐ Don't know
- ☐ Don't want to answer

(To be filled in by agency or clinic staff)

Agency or clinic: **Agency staff or provider name or ID:**

Phone: **Address:**

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Language (*Interpreters are available at no charge*)

4a. What language or languages do you **use at home**? _____

Skip to question 7 if you indicated English only

4b. In what language do you want us to communicate in **person, on the phone, or virtually** with you?

_____

4c. In what language do you want us to **write** to you? _____

5a. Do you need or want an **interpreter** for us to communicate with you?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

☐ Spoken language interpreter
☐ American Sign Language interpreter
☐ Other ***(please list)***: _____
☐ Deaf Interpreter for DeafBlind, additional barriers, or both
☐ Contact sign language (PSE) interpreter

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Don't know ☐ Don't want to answer

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.*)		Yes	***If yes**, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking
7.	Are you **deaf** or do you have **serious difficulty hearing**?						
8.	Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?						
	Please stop now if you/the person is under age 5						
9.	Do you have **serious difficulty walking or climbing stairs**?						
10.	Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?						
11.	Do you have **difficulty dressing or bathing**?						
12.	Do you have **serious difficulty learning how to do things most people your age can learn**?						
13.	Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?						
	Please stop now if you/the person is under age 15						
14.	Because of a **physical, mental or emotional condition**, do you have **difficulty doing errands alone** such as visiting a doctor's office or shopping?						
15.	Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?						

Print Save Reset

Community Health Centers
OF BENTON & LINN COUNTIES

Patient Label

Sexual Orientation and Gender Identity (SOGI)

Sexuality

Sexual Orientation:

- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ Omnisexual
- ☐ Asexual
- ☐ Other: _____
- ☐ Don't know
- ☐ Decline to answer

Gender Identity

Gender Identity:

- ☐ Female
- ☐ Male
- ☐ Transgender female
- ☐ Transgender male
- ☐ Non-binary
- ☐ Genderqueer
- ☐ Questioning
- ☐ Two Spirit
- ☐ Other: _____
- ☐ Decline to answer

Sex assigned at birth:

- ☐ Female
- ☐ Male
- ☐ Unknown
- ☐ Intersex
- ☐ Unknown
- ☐ Not recorded on birth certificate
- ☐ Decline to answer

Pronouns

Pronouns:

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/them/theirs
- ☐ Ze/hir/hirs
- ☐ Ey/em/eirs
- ☐ Xe/xem/xyrs
- ☐ Ve/vir/vis
- ☐ Other: _____
- ☐ Patient name
- ☐ Unknown
- ☐ Decline to answer

Community Health Centers
OF BENTON & LINN COUNTIES

Patient Label

Adult Medical and Social History

Patient Information			
Legal Name:		Today's Date:	
Preferred Name:		Date of Birth:	
Sex at birth: ☐ Female ☐ Male ☐ Unknown ☐ Not recorded ☐ Decline to answer ☐ Intersex			
Occupation:		Employer:	
Marital Status:	☐ Divorced ☐ Domestic Partner ☐ Legally Separated	☐ Married ☐ Significant Other ☐ Single	☐ Unknown ☐ Widowed ☐ Other: _____
Number of Children:		Years of Education:	

Surgeries	Date

Hospitalizations:	Date

Medications *(please list any prescription medications, over the counter, vitamins, and herbs)*

Medication	Dosage	Frequency

Family Status		
Relationship	Alive	Deceased
Mother	☐	☐
Father	☐	☐
Sister	☐	☐
Brother	☐	☐
Daughter	☐	☐
Son	☐	☐
Other: (describe)	☐	☐

Family History *(please check all that apply)*

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol/Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer Type: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sudden Death	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vision Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: (describe)	☐	☐	☐	☐	☐	☐	☐	☐	☐

Allergies
☐ None

Continued on next page

Substance Use

Smoking: ☐ Never ☐ Former ☐ Every Day ☐ Some Days ☐ Unknown
Type(s): ☐ Cigarette ☐ Pipe ☐ Cigars
Use/week: _____

Smokeless: ☐ Never ☐ Former ☐ Current ☐ Unknown

E-Cigarettes / Vaping: ☐ Current every day user ☐ Current some day user ☐ Former user ☐ Never user

Type(s): ☐ Nicotine ☐ THC ☐ CBD ☐ Flavoring ☐ Other: _____

Device(s): ☐ Disposable ☐ Pre-filled or Refillable Cartridge ☐ Refillable Tank ☐ Pre-filled Pod ☐ Other: _____

Alcohol: ☐ Yes ☐ Not Currently ☐ Never
Type: ☐ Bottles of beer ☐ Glasses of wine ☐ Shots / hard liquor
Use/week: _____

Drug: ☐ Yes ☐ Not Currently ☐ Never
Type(s): ☐ Amphetamines ☐ Barbiturates ☐ Benzodiazepines ☐ Cocaine ☐ Crack ☐ Ecstasy ☐ Fentanyl ☐ Hashish ☐ Heroin ☐ IV ☐ Ketamine ☐ LSD ☐ Marijuana ☐ Mescaline ☐ Methamphetamine ☐ Nitrous Oxide ☐ Opioids ☐ PCP ☐ Psilocybin ☐ Solvent Inhalants ☐ Stimulants ☐ Vaping ☐ Other: _____

Sexual Orientation and Gender Identity (SOGI)

Sexual Orientation:
☐ Straight or heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Queer ☐ Omnisexual ☐ Asexual ☐ Something else ☐ Don't know ☐ Decline to answer

Gender identity:
☐ Female ☐ Male ☐ Transgender female ☐ Transgender male ☐ Non-binary/ genderqueer ☐ Other: _____ ☐ Questioning ☐ Two Spirit ☐ Decline to answer

Pronouns:
☐ She/her/hers ☐ He/him/his ☐ They/them ☐ Ze/hir/hirs ☐ Ey/em/eirs ☐ Xe/xem /xyrs ☐ Other: _____ ☐ Ve/vir/vis ☐ Patient's name ☐ Unknown ☐ Decline to answer

Sexual Activity

Sexual Activity: ☐ Yes ☐ Not Currently ☐ Never

Partners: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Decline to answer ☐ Non-binary ☐ Questioning ☐ Other: _____

STI Risk:
Do you use condoms to protect against sexually transmitted illness? ☐ Yes ☐ No
Number of sexual partners in the last 3 months: _____
Number of sexual partners in the last 12 months: _____
Do you have any risk factors for HIV (STI's HIV+ partner, needle use, blood transfusion, bisexual partner, etc.)? ☐ Yes ☐ No
Do you have a history of any sexually transmitted illness?
☐ HIV ☐ Syphilis ☐ Chlamydia ☐ Gonorrhea ☐ Hepatitis B ☐ Herpes ☐ HPV ☐ Other: _____
Have you ever been a victim of physical or sexual abuse? ☐ Yes ☐ No

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Sexual History

Are your sex partners: ☐ a person with a penis ☐ a person with a vagina

What body parts do you use when you have sex? ☐ Penis ☐ Vagina ☐ Anus ☐ Mouth

Has there been any change in your sexual desire? ☐ Yes ☐ No

If yes, please describe the change:

Birth Control / Protection	Current Method	Past Method
Abstinence	☐	☐
Cervical Cap	☐	☐
Condom	☐	☐
Diaphragm	☐	☐
Fertility Awareness Method	☐	☐
Hormonal Patch	☐	☐
Implant	☐	☐
Injection	☐	☐
Inserts	☐	☐
I.U.D.	☐	☐
IUS	☐	☐
Menopause	☐	☐
Pill	☐	☐
Rhythm	☐	☐
Spermicide	☐	☐
Sponge	☐	☐
Surgical	☐	☐
Vagiinal Ring	☐	☐
Vastectomy	☐	☐
Withdrawl	☐	☐

Other Reproductive Surgery:

Have you ever been tested for HIV? ☐ Yes ☐ No

Would you like to be tested for HIV? ☐ Yes ☐ No

Do you have pain during intercourse? ☐ Yes ☐ No

Do you have any questions or concerns about your sexual health?

Is there anything else you would like your medical provider to know about you?

Have you had any problems with any method of birth control? ☐ Yes ☐ No

If yes, please explain:

Are you using birth control now? ☐ Yes ☐ No

Menstrual / Pregnancy History

How old were you when you started having periods?

☐ Never Pregnant ☐ Currently Pregnant ☐ Planning on becoming pregnant in the coming year

Date last pregnancy ended:	# of Pregnancies:	# of Live Births:	# of Ectopic Pregnancies:
# of Elective/Therapeutic Abortions:	# of Miscarriages:	# of Living Children:	
Pre-menstrual dysphoric disorder: ☐ Yes ☐ No		When did your last menses start?	
Do you have cramps? ☐ Yes ☐ No	Bleeding: ☐ Light ☐ Medium ☐ Heavy		Spotting ☐ Yes ☐ No

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Menstrual / Pregnancy History, continued
When was your last pap smear?
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
If your pap was abnormal, how was this treated?
If you were born between 1940 – 1970, did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

Vaccine and Test / Exam Record

Immunizations	Date	Location
Flu Vaccine		
Tetanus		
Pneumonia		
MMR		
HPV		
Hep A/B		
T.B. Test		
Rubella		
Mumps		
Tdap		
Measles		

Tests / Exams	Date	Location
Eye Exam		
Stool Blood Test		
Colonoscopy		
HIV test		
Chlamydia / Gonorrhea Screen		
Bone Density		
Mammogram		
Cholesterol Test		

Personal Concerns					
Have you been in the military?	☐ Yes	☐ No	Do you have concerns about weight?	☐ Yes	☐ No
Have you had a blood transfusion?	☐ Yes	☐ No	Do you follow a special diet?	☐ Yes	☐ No
Do you have a caffeine concern?	☐ Yes	☐ No	Do you have a back care concern?	☐ Yes	☐ No
Exposure to occupational hazards?	☐ Yes	☐ No	Do you exercise?	☐ Yes	☐ No
Exposure to hobby hazards?	☐ Yes	☐ No	Do you wear a bike helmet?	☐ Yes	☐ No
Do you have sleep concerns?	☐ Yes	☐ No	Do you use a seat belt?	☐ Yes	☐ No
Do you have concerns about stress?	☐ Yes	☐ No	Comments:		