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

Benton County Dental Services

Dental Health History

Patient's Dental Health			
Patient Name			**DOB**
Are you currently experiencing pain? ☐ Yes ☐ No		When was your last dental exam?	
if yes, please provide details:			
Do you have difficulty opening your mouth?	☐ Yes ☐ No	Do you clench or grind your teeth?	☐ Yes ☐ No
Do you have difficulty chewing?	☐ Yes ☐ No	Do you have dry mouth?	☐ Yes ☐ No
Does your jaw click, pop, or lock open?	☐ Yes ☐ No	Are your teeth sensitive to hot or cold?	☐ Yes ☐ No
Do you have history of sores or growths in your mouth?			☐ Yes ☐ No
Do your gums bleed when you brush or floss your teeth?			☐ Yes ☐ No
Does dental treatment make you nervous?			☐ Yes ☐ No
Have you had any injury to your face or mouth?			☐ Yes ☐ No
Have you ever had problems with dental treatment or dental anesthetic?			☐ Yes ☐ No
Does your PCP require you to pre-med before dental treatments?			☐ Yes ☐ No
Have you ever taken Fen-Phen or Redux?			☐ Yes ☐ No
Have you ever taken Bisphosphonates (Fosmax, Boniva, Actonel, Aredia, Zometa, ect.)?			☐ Yes ☐ No

Patient's Medical History					
ADD/ADHD	☐ Yes ☐ No	COPD	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Depression	☐ Yes ☐ No	Meningitis	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Mental health disorder	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Drug addiction	☐ Yes ☐ No	MRSA infection	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Emphysema/COPD	☐ Yes ☐ No	Myocardial infarction	☐ Yes ☐ No
Arthritis/Joint disorder	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Nerve/muscle disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Heart failure	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Bisphosphonate therapy	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Broken jaw	☐ Yes ☐ No	Heart endocarditis	☐ Yes ☐ No	Sickle cell anemia	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Blood transfusions	☐ Yes ☐ No	STD	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No
Clotting disorder	☐ Yes ☐ No	Hyperlipidemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Congenital heart defect	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	TB Disease	☐ Yes ☐ No
		Kidney disease	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No

Do you have implants/Artificial joints?	☐ Yes ☐ No	If yes, what joint? ☐ Hip ☐ Knee ☐ Other:_____
Have you had a major surgery?	☐ Yes ☐ No	If yes, what year? _____ Type of operation_____
Have you consumed alcohol with in the last 24 hours?		☐ Yes ☐ No
Do you smoke or use chewing tobacco?		☐ Yes ☐ No
If yes, how much per day? _____ How many years? _____		

Women:	Are you taking birth control meds?	☐ Yes ☐ No	Are you or could you be pregnant?	☐ Yes ☐ No

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Physicians Name: (If not part of Benton County Health Services)

Medications	
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:
Medication:	Condition:

Allergies			
Aspirin	☐ Yes ☐ No	Ibuprofen	☐ Yes ☐ No
Sulfa Drugs/Sulfites/Sulfides	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Amoxicillin	☐ Yes ☐ No
Local anesthetics	☐ Yes ☐ No	Latex, Metals, Plastics	☐ Yes ☐ No
Other medications allergies:			

Patient Signature

_____ _____

Patient signature Date

_____ _____

Provider signature Date

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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			