MULTNOMAH COUNTY student HEALTH CENTER

Name:_____
MRN: _____
DOB:___/___/___ID#_____
Sex: M _ F (or place label here)

NEW CLIENT INFORMATION – Part 1

Last Name:_____First:_____Middle Initial: _____
Date of Birth:_____Preferred Name:_____

Sex assigned at birth:
❑ Female ❑ Male

Student Cell:_____Home Phone: _____
Can we contact you at home? ❑ Yes ❑ No

Address:_____APT#_____
City/State:_____Zip: _____

What school do you attend?_____ Grade: _____

Emergency Contact (Required)

Who is a responsible adult that we can notify in case of emergency: _____
Relationship:_____Home Phone: _____
Cell Phone:_____Work Phone: _____

Other Contacts

Parent/guardian/other (first & last name):_____Relationship:_____
Home#:_____Cell#:_____Work#:_____
Date of Birth_____

Parent/guardian/other (first & last name):_____Relationship:_____
Home#:_____Cell#:_____Work#:_____
Date of Birth_____

I live with my (check all that apply):
❑ Mother(s) ❑ Father(s) ❑ Foster Parent(s) ❑ Grandparent(s)
Other - Name:_____ Relationship: _____

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NEW CLIENT INFORMATION – Part 2

Household Information

Who lives in your home?

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Where do you usually go for medical care? Doctor: _____

Where do you usually go for dental care? Dentist: _____

Insurance Information

Providing us with your insurance coverage information allows us to bill for services and reduces our need for public funding so we can provide care to as many students as possible. If your insurance doesn't pay for all or part of the cost you are not responsible for any out-of-pocket expenses for services received at a Student Health Center.

Families with no health insurance or who do not provide insurance information are referred for screening to see if they qualify for the Oregon Health Plan or other insurance programs.
We strongly encourage you to apply for this valuable coverage.

❑ **I have Medicaid/Oregon Health Plan** *Please let us make a copy of your insurance card*

Name of Insurance Company: _____ **Effective date:** _____

Company/Claim Address (including city/state/zip): _____

_____

Phone number: _____ **Policy/ID/Patient number:** _____

Group number: _____

Subscriber (parent/guardian who provides insurance) Name: _____

Date of birth: _____ Social Security Number (SSN): _____

Relationship to student: _____

Is the student covered under more than one policy? Please give us information for all insurance coverage, and let us know which one is first (primary).