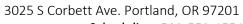




PATIENT REGISTRATION

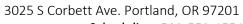
(Please print clearly)

DEMOGRAPHICS:				
Patient Legal Full Name:			Date of Birth:	
Previous Names/Alias:				
What is your preferred name?				
Street or Mailing Address:				
City:	State:	Zip	Code:	
Preferred Contact Phone Number? (Select one):	□ Mobile	□ Home	□ Work	
Mobile Phone:	Home Phone:			
Work Phone: Er	mail Address:			
How may we contact you? (Select all that apply):	□ US Mail	□ Phone	□ Email	□ Text
May we leave you confidential voicemail messages?	□ Yes	□ No		
Social Security Number:	(use	ed only for ident	tity verification o	and privacy)
Do you have Medicare?	Part B 🗆 Adva	ntage (Part C, lis		
Primary Insurance Company:				
Claims Address:				
Subscriber Name (if other than patient): Member ID#: Group #:			ber ID #:	
Member ID#: Group #:		Subscri	ber 10 #	
Secondary Insurance Company:				
Claims Address:				
Subscriber Name (if other than patient):		Bir	th date:	
Member ID#: Group #:		Subscri	her ID #·	



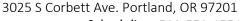


Name:		Relationshin to	the patient:
Address (if different from patient):			
			Zip:
Social Security Number:			
			:
EMERGENCY CONTACT:			
Name:		Relationsh	nip:
Address:			
			::
Legal Guardian (if under 18/other)?	Yes □ No Is	this person allowed	d to schedule visits for you: 🗆 Yes 🗆 No
PRIMARY CARE PROVIDER:			
☐ I wish to establish Primary Care with	NUNM Health C	enters.	
☐ I see NUNM for ancillary/adjunctive	care only.		
My Primary Care Physician (PC	:P) is:		
At (Clinic Name):			
☐ I do not have a Primary Care Physicia			
INTERPRETER REQUIRED? Yes	□ No LAN	IGUAGE:	
Employment Status (check all that app	ly): □ Full Time	□ Part Time □ Not	Employed □ Retired □ Seasonal
	•	t (Part Time) 🗆 NUNI	• •
, ,	•	,	
Housing Status: ☐ Not Homeless ☐ F	Homeless □ At F	Risk □ Transitional I	Housing □ Living in Shelter
What was your assigned sex at birth?	□ Female	□ Male	□ (other)
What is your current legal sex?	□ Female	□ Male	☐ X (Only alternative accepted in Oregon)
What is your current gender identity?	□ Female	□ Male	□ (other)
Which pronoun(s) do you use?	□ She/Her/Her	s □ He/Him/His	□ They/them/their
	□ (other)		





Ethnic Groups: Cuban Mexican, Mexican American, Chicano/a Puerto Rican
☐ Multiple Hispanic, Latino/a, or Spanish Origins ☐ Another Hispanic, Latino/a, or Spanish Origin
□ Non-Hispanic or Latino/a □ Other □Refused
Race: <i>(Select all that apply)</i> : Alaskan Native American Indian Asian Indian Black/African American
□Chinese □ Filipino □ Guamanian or Chamorro □ Japanese □ Korean
□ Native Hawaiian □ Samoan □ Vietnamese □ White □ Other Asian
□ Other Pacific Islander □ Unknown □ Refused
Ethnic Background(s):
Are you a US Veteran? □ Yes □ No
COMPASSIONATE CARE APPLICATION: (Optional)
The Compassionate Care Program is a schedule of discounts based upon household size and annual combined gross
income of all home residents 15 years or older. This program requires proof of income and will expire 1 year after the
application date. Renewal paperwork will be provided each year.
COMBINED GROSS INCOME OF HOUSEHOLD:
Per: Month Year Week 2 Weeks Twice a Month
NUMBER OF PEOPLE IN HOUSEHOLD:
AUTHORIZATION: (Please sign and date below)
• I certify that the information provided on this form is true and correct to the best of my knowledge.



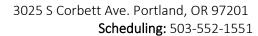


Please be sure to bring your photo ID and all insurance cards for each visit to NUNM. If you complete this form online, please upload all information you have, otherwise, please use this checklist for information to bring to your first appointment.

Photo ID Front:	Photo ID Back:
Medicaid Card Front:	Medicaid Card Back:
Primary Insurance Front:	Primary Insurance Back:
Secondary Insurance Front:	Secondary Insurance Back:
Proof of Income for Compassionate Care Application: _	

PATIENT RIGHTS & RESPONSIBILITIES:

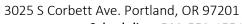
The full documentation of NUNM's Patient Rights and Responsibilities is available for review in the health center's lobby or by request at the front desk. You can also review a copy online at: https://nunmhealthcenters.com/new-patients/.





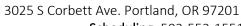
ADULT HEALTH HISTORY

Last Name	 First Name	Middle Initial Date of Birth							
What is the primary reason for your visit to our Health Center today?									
		v-up visits?							
what additional concern(s) would you i	ike to address at folio t	v-up visits:							
When did the problem(s) begin?									
Have these conditions been treated by a	another health care pi	ovider in the past?							
If YES, How long ago?									
Provider?									
Where?									
Is the problem(s) the result of an autom	nobile accident and/or	a work injury? Li Yes Li No							
If YES, specify which concern was relate	d to this accident/inju	ry:							
Allergies									
List medications, food, or environment	tal allergens	Reaction							
Medications									
Name of medication/supplement	Strength/Dose	Frequency Taken and Route (oral, topical)							



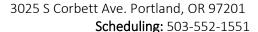


Medical Histor	y : Do y	ou ha	ve a histo	ory of ar	ny of the	e followi	ing? <i>(Pl</i>	ease sel	ect all t	hat app	ly)			
☐ Adrenal Dis	•		☐ Cance		•		rt Disea					Disease	!	
☐ Anemia			☐ COPE)	☐ Hyperlipidemia ☐ L			Liver Disease						
☐ Anxiety			☐ Depre	ession		□ Нур	ertensi	on			Stroke			
☐ Arthritis/Jo	int disor	der	☐ Diabe	tes Mel	llitus	☐ Infla	ammato	ry Bowe	el Diseas	se 🗆	Thyroid	d Diseas	e	
☐ Asthma			☐ Diges	tive Pro	blem	☐ Irrit	able Bo	wel Synd	drome					
☐ Other:														
Surgeries / Hos														
List all past sur	geries o	r maj	or hospita	alization	IS						Date(s) (Mon	th and \	Year)
Do you have in	-		cial joints	or discs	, metal	or anytl	hing tha	t could	impact [·]	therapy	or imag	ging? 🗆	Yes 🗆 I	No
If YES, please d	lescribe:													
Familia Historia	DI	((\)/!!		£ +1-	- f:I.			1		r				
Family History:	Place a	n X	next to a	ny or the	e ramily T	nistory	you na	ve know	leage o	1:	1	1	l	l
	Alcohol/ Drug Addiction	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	High Blood Pressure	Kidney Disease	Mental Illness	Stroke	Vision Problems	Gastrointestinal
Mom														
Dad														
Sister														
Brother														
Mom's Mom														
Mom's Dad														
Dad's Mom														
Dad's Dad														
Other/Unknown:														
Immunization History:														
Did you complete your childhood vaccinations? ☐ Yes ☐ No														
Have you had a tetanus booster? ☐ Yes ☐ No IF YES, what was the date of this booster?														
Have you received a flu shot this year? ☐ Yes ☐ No IF NO, would you like to get a flu shot today? ☐ Yes ☐ No														





Smoking History: (Please select all that apply) □ Never Smoker □ Former Smoker □ Current Every Day Smoker □ Current Smoker, Some Days □ Passive Smoke Exposure – Never Smoker □ Other:							
Check all that apply: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ E-Cigarette/Vaping ☐ Other:							
Type of Products Use	ed: ☐ Nicotine ☐ THC	☐ CBD ☐ Flavoring	☐ Other:				
Packs per day:	Years of smoking:	Start Date:	Quit	Date:			
Are you interested in learning about options to quit smoking?: ☐ Yes ☐ No							
Alcohol Use: (Please	select all that apply)						
Do you drink alcohol	? Yes No	Not Currently \(\square\) No	ever				
If "YES", how many o	of the following per <u>week?</u>	glasses of wine	e cans of l	beer shots of liquor			
	any of the following recre						
•	☐ Barbiturates ☐ Ben	•	_				
•	☐ Fentanyl ☐ Hasl			☐ Vaping			
	□ LSD □ Can		caline \square Metha	·			
☐ Nitrous Oxide	☐ Opioids ☐ PCP	☐ Psilo	cybin 🗆 Solver	nt Inhalants			
Sexual Orientation a	nd Gender Identity: (Please	e select all that apply)					
Do you think of yourself as: ☐ Straight or heterosexual ☐ Bisexual ☐ Lesbian ☐ Asexual ☐ Gay ☐ Queer							
	☐ (self describe):_		□ Don't know □	☐ Choose not to disclose			
What is your gender	What is your gender identity?						
☐ Cisgender Female	☐ Cisgender Male ☐	Transgender Female/	rans Woman 🛚 🗀] Transgender Male/ Trans Man			
☐ Genderqueer	☐ Genderqueer ☐ Nonbinary ☐ Two Spirit ☐ Choose not to disclose ☐ (self describe):						
Are you sexually active? ☐ Yes ☐ Never ☐ Not Currently							
Partners? (Please select all that apply) ☐ Female ☐ Male ☐ (self describe):							
What is your current	protection and/or birth co		check all that app	ly):			
☐ Abstinence	☐ Cervical Cap	☐ Condom	☐ Diaphragm	☐ Fertility Awareness			
☐ Hormonal Patch	☐ Implant (Nexplanon)	☐ Injection (Depo)	☐ IUD (Copper)	☐ IUD (Hormonal)			
☐ Menopause	☐ None	☐ Pill	☐ Rhythm	☐ Spermicide			
☐ Sponge	☐ Surgical	□ Vaginal Ring	□ Vasectomy	☐ Withdrawal			
Obstetric and Gynecologic History							
Age at first menses: First day of last menstrual period:// Age at menopause:							
Age at first pregnancy: Number of months breastfeeding: Number of pregnancies:							
Number of live births: Number of miscarriages: Number of abortions:							
PHQ-2: Over the past 2 weeks, how often have you been bothered by any of the following problems?							





Little interest or pleasure in doing things: ☐ nearly every day ☐ more than half the days ☐ several days ☐ not at all Feeling down, depressed, or hopeless: ☐ nearly every day ☐ more than half the days ☐ several days ☐ not at all **Food Security:** Please answer the following questions regarding your social history: In the past year, we worried whether our food would run out before we could get more: ☐ often true ☐ sometimes true □ never □ don't know /refused In the past year, the food we bought just didn't last and we didn't have money to get more: ☐ often true ☐ sometimes true ☐ never ☐ don't know /refused Review of Systems: Please mark any current symptoms (in the past 2 weeks). Constitution and Skin ☐ Fever ☐ Chills ☐ Sweating ☐ Weight Gain ☐ Rash ☐ Weakness ☐ Itching ☐ Weight Loss ☐ Easy Bruising/ Bleeding ☐ Excessive Thirst ☐ Hot/Cold Intolerance Head, Eyes, Ears, Nose, Throat ☐ Sore Throat ☐ Congestion ☐ Ear Pain ☐ Sinus Pain ☐ Nosebleeds ☐ Hearing Loss ☐ Ringing in Ears ☐ Ear Discharge ☐ Vision Changes ☐ Eye Redness or Discharge ☐ Eye Pain ☐ Light Sensitivity Heart and Lungs ☐ Chest Pain ☐ Palpitations ☐ Leg Swelling ☐ Leg Cramping ☐ Cough ☐ Shortness of breath ☐ Coughing up blood ☐ Sputum Production Gastrointestinal ☐ Heartburn ☐ Nausea □ Vomiting ☐ Abdominal Pain ☐ Diarrhea ☐ Constipation ☐ Blood in Stool ☐ Black/Tarry Stools Genitourinary ☐ Painful Urination ☐ Abnormal Discharge ☐ Urinary Urgency ☐ Urinary Frequency ☐ Blood in Urine ☐ Testicular Masses ☐ Sexual Difficulty ☐ Hernias Musculoskeletal ☐ Neck or Back Pain ☐ Muscle Pain ☐ Joint Pain ☐ Falls Neurological ☐ Dizziness □ Weakness ☐ Fainting ☐ Tingling ☐ Tremor ☐ Seizures ☐ Speech Change ☐ Headaches **Psychiatric** ☐ Depression ☐ Nervous/Anxious ☐ Insomnia ☐ Suicidal Ideas ☐ Hallucinations ☐ Memory Loss ☐ Confusion ☐ Agitation