nunm HEALTH CENTERS

3025 S Corbett Ave. Portland, OR 97201
Scheduling: 503-552-1551

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: _____ Email 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: _____ *(used only for identity verification and privacy)*

INSURANCE:

****NUNM is not contracted with Federal Medicare, however Medicare will affect the services we can offer****

Do you have Medicare? □ Yes □ No Is this your primary insurance? □ Yes □ No

Medicare Plan (check all that apply): □ Part A □ Part B □ Advantage (Part C, list as primary insurance below)

Subscriber ID #: _____ Effective Date (if known): _____

Primary Insurance Company: _____

Claims Address: _____

Subscriber Name *(if other than patient)*: _____ Birth date: _____

Member ID#: _____ Group #: _____ Subscriber ID #: _____

Secondary Insurance Company: _____

Claims Address: _____

Subscriber Name *(if other than patient)*: _____ Birth date: _____

Member ID#: _____ Group #: _____ Subscriber ID #: _____

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GUARANTOR: *(Usually "Self" unless under 18 or in care management)*

Name: _____ Relationship to the patient: _____

Address *(if different from patient)*: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Guarantor Primary Language: _____ Phone: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Legal Guardian (if under 18/other)? □ Yes □ No **Is this person allowed to schedule visits for you**: □ Yes □ No

PRIMARY CARE PROVIDER:

□ I wish to establish Primary Care with NUNM Health Centers.

□ I see NUNM for ancillary/adjunctive care only.

My Primary Care Physician (PCP) is: _____

At (Clinic Name): _____

□ I do not have a Primary Care Physician and do not wish to establish Primary Care with NUNM at this time.

INTERPRETER REQUIRED? □ Yes □ No LANGUAGE: _____

Employment Status *(check all that apply)*: □ Full Time □ Part Time □ Not Employed □ Retired □ Seasonal
□ Self-Employed □ Student (Full Time) □ Student (Part Time) □ NUNM Student □ NUNM Staff

Housing Status: □ Not Homeless □ Homeless □ At Risk □ Transitional 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/Hers	□ He/Him/His	□ They/them/their
	□ *(other)* _____		

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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: *(Select all that apply)*: □ 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.***

_____ _____
Signature of Patient OR **Parent / Legal Guardian Signature** (*if patient is under 15)* **Date**

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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/.

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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? _____

What additional concern(s) would you like to address at **follow-up visits**? _____

_____

When did the problem(s) begin? _____

Have these conditions been treated by another health care provider in the past?

If YES, How long ago? _____

Provider? _____

Where? _____

Is the problem(s) the result of an automobile accident and/or a work injury? ☐ Yes ☐ No

If YES, specify which concern was related to this accident/injury: _____

Allergies	
List medications, food, or environmental allergens	Reaction

Medications		
Name of medication/supplement	Strength/Dose	Frequency Taken and Route (oral, topical)

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Medical History: Do you have a history of any of the following? *(Please select all that apply)*

☐ Adrenal Disorder	☐ Cancer	☐ Heart Disease	☐ Kidney Disease
☐ Anemia	☐ COPD	☐ Hyperlipidemia	☐ Liver Disease
☐ Anxiety	☐ Depression	☐ Hypertension	☐ Stroke
☐ Arthritis/Joint disorder	☐ Diabetes Mellitus	☐ Inflammatory Bowel Disease	☐ Thyroid Disease
☐ Asthma	☐ Digestive Problem	☐ Irritable Bowel Syndrome	

☐ Other: _____

Surgeries / Hospitalizations

List all past surgeries or major hospitalizations	Date(s) (Month and Year)

Do you have implants, artificial joints or discs, metal or anything that could impact therapy or imaging? ☐ Yes ☐ No
If YES, please describe:

Family History: Place an "X" next to any of the family history you have knowledge of:

	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

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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 Used: ☐ 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 ☐ Never

If "YES", how many of the following per week?: _____ glasses of wine _____ cans of beer _____ shots of liquor

Do you currently use any of the following recreational drugs? *(Please select all that apply)*

☐ Amphetamines ☐ Barbiturates ☐ Benzodiazepines ☐ Cocaine ☐ Crack ☐ Stimulants
☐ Ecstasy ☐ Fentanyl ☐ Hashish ☐ Heroin ☐ IV ☐ Vaping
☐ Ketamine ☐ LSD ☐ Cannabis ☐ Mescaline ☐ Methamphetamine ☐ Other
☐ Nitrous Oxide ☐ Opioids ☐ PCP ☐ Psilocybin ☐ Solvent Inhalants

Sexual Orientation and Gender Identity: *(Please 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 identity?

☐ Cisgender Female ☐ Cisgender Male ☐ Transgender Female/ Trans Woman ☐ Transgender Male/ Trans Man
☐ 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 control method? (Please check all that apply):

☐ 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?

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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	☐ Itching	☐ Weakness	☐ Weight Loss
☐ Easy Bruising/ Bleeding		☐ Excessive Thirst	☐ Hot/Cold Intolerance

Head, Eyes, Ears, Nose, Throat

☐ Sore Throat	☐ Sinus Pain	☐ Congestion	☐ Ear Pain
☐ Nosebleeds	☐ Hearing Loss	☐ Ringing in Ears	☐ Ear Discharge
☐ Vision Changes	☐ Eye Pain	☐ Eye Redness or Discharge	☐ 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	☐ Hernias	☐ Testicular Masses	☐ Sexual Difficulty

Musculoskeletal

☐ Muscle Pain	☐ Joint Pain	☐ Neck or Back Pain	☐ Falls

Neurological

☐ Dizziness	☐ Weakness	☐ Tingling	☐ Fainting
☐ Tremor	☐ Seizures	☐ Speech Change	☐ Headaches

Psychiatric

☐ Depression	☐ Nervous/ Anxious	☐ Insomnia	☐ Suicidal Ideas
☐ Hallucinations	☐ Memory Loss	☐ Agitation	☐ Confusion