NKN STUDENT HEALTH & WELLNESS CENTER

24705 US-101, Rockaway Beach, OR 97136
Mailing Address: PO Box 176, Wheeler, OR 97147
Telephone: 503-355-3500 | Fax: 844-720-1901

Received by: ___________
Entered by: ___________

Nehalem Bay Health Center (formerly known as Rinehart Clinic) is the medical sponsor for NKN Student Health & Wellness Center and operates according to the guidelines set forth by Oregon Law (Oregon Revised Statutes: 109.610, 109.640, 109.675, 109.680). All services will be provided by Nehalem Bay Health Center (NBHC) care team.

Today's date: ___________________

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (first, middle, last): _____________________________________ Preferred name: ______________________

SSN: ____________________ Gender: __________ Birthdate: ___________ Preferred pronouns: ____________

Mailing Address: ____

Physical Address (if different): ____

Home Phone: __________________________________ May we leave a detailed message? ☐ Yes ☐ No

Cell Phone: ____________________________________ May we leave a detailed message? ☐ Yes ☐ No

Email Address: ____

Emergency Contact – Who should we contact in case of an emergency?

Name: ____ Relationship to you: ______________________________

Primary phone: _________________________________ Other phone number: _____________________________

Do you have a primary health care provider? ☐ Yes ☐ No

If yes, please list your provider's name: ____

Would you like NKN Student Health & Wellness Center/NBHC to be your primary care provider? ☐ Yes ☐ No

PARENT/GUARDIAN INFORMATION (Only needed for minors under age 18.)

Mother's Name: ______________________ Phone: __________________ Primary Language: __________________
Interpreter Needed? ☐ Yes ☐ No

Father's Name: _______________________ Phone: __________________ Primary Language: __________________
Interpreter Needed? ☐ Yes ☐ No

Guardian's Name: _____________________ Phone: __________________ Primary Language: _________________
(If other than parent.)
Interpreter Needed? ☐ Yes ☐ No

Name: ______________________________ DOB: _______________ Date: ______________

OTHER INFORMATION

Preferred Language: __________________________________ Do you need an interpreter? ☐ Yes ☐ No

Are you visually impaired? ☐ Yes ☐ No Are you hard of hearing? ☐ Yes ☐ No

Housing Situation – Please check the item or items that best describe your household:

Do you consider yourself homeless? ☐ Yes ☐ No

☐ Currently not homeless, but have been in the last 12 months. ☐ Living with friends/family.

☐ Living in a shelter. ☐ Street/Camp/Bridge. ☐ Living in transitional housing.

With whom do you live? ☐ Mother ☐ Father ☐ Both Mother and Father ☐ Other: ___________________

Race & Ethnicity

Ethnicity (please check one): ☐ Non-Hispanic ☐ Mexican, Mexican American, Chicano/a ☐ Cuban

☐ Puerto Rican ☐ Another Hispanic/Latino/a or Spanish Origin ☐ Unknown ☐ I'd rather not answer

Race/Heritage (please check all that apply):

☐ Alaskan Native ☐ American Indian ☐ Asian Indian ☐ Black/African American ☐ Chinese

☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian

☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Unknown ☐ I would rather not answer

Veteran Status: Have you ever served in the armed services? ☐ Yes ☐ No ☐ Would rather not answer

INSURANCE INFORMATION OF PERSON RESPONSIBLE FOR PAYMENT:

Do you have health insurance? ☐ No health insurance ☐ Oregon Health Plan ☐ Private Insurance

If you have health insurance, please fill out the following:

Insurance Company: ____________________________ Group Number: ______________________________

ID#: ______________________________________ Effective Date: ______________________________

Policy Holder's Name: ___________________________ Relationship to Patient: _________________________

Policy Holder's Birthdate: _________________________ Policy Holder's SSN: ____________________________

Do you have any other medical insurance? ☐ Yes ☐ No If yes, please fill out the section below.

Insurance Company: ____________________________ Group Number: ______________________________

ID#: ______________________________________ Effective Date: ______________________________

Policy Holder's Name: ___________________________ Relationship to Patient: _________________________

Policy Holder's Birthdate: _________________________ Policy Holder's SSN: ____________________________

Name: _________________________________ DOB: _________________ Date: ________________

ACKNOWLEDGEMENTS

Please initial all boxes below to acknowledge that you have read or received the following:

_________ **Patient Rights and Responsibilities/Notice of Privacy Practices** – I acknowledge that I have received a copy of NKN Student Health & Wellness Center's Patient Rights and Responsibilities/Notice of Privacy Practices.

_________ **Acknowledgement of Mandatory Reporting** – I understand that NKN Student Health & Wellness Center is required by law to report any unsafe situation to Child Welfare or law enforcement.

Neah-Kah-Nie School District Information

Which school do you attend? ☐ Nehalem Elementary School ☐ Garibaldi Grade School ☐ NKN Middle School ☐ NKN High School ☐ Homeschool or Online School w/District Activities (Sports) ☐ Other:___________________