UNIVERSITY of WESTERN STATES
Health Centers

NEW PATIENT REGISTRATION

Patient Information

Full Legal Name: _____

Preferred Name: _____

Social Security # _____ Date of Birth _____

Gender: ☐ Female ☐ Male ☐ Trans F to M ☐ Trans M to F ☐ Other ☐ Choose Not to Disclose

Street Address _____

City _____ State _____ Zip _____

Billing Address _____ ☐ Same as Street

City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ ☐ Same as Home

Work _____

Email Address _____

Communication Preference: ☐ No Preference ☐ Do Not Contact ☐ Mail ☐ Phone ☐ Email ☐ MyChart

Text Messages OK? ☐ Yes ☐ No (please provide a mobile number above to receive text messages)

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race (check all that apply): ☐ Alaskan Native ☐ Native American ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unknown ☐ Choose Not to disclose

Primary Language (if not English) _____ Written _____

Do you need an interpreter? ☐ Yes ☐ No _____

Emergency Contact Information

Emergency Contact _____ Relationship _____

Emergency Phone (Home) _____ (Work) _____

Employment Background

Are you currently employed? ☐ Yes ☐ No Employment Status: ☐ Full Time ☐ Part Time ☐ Student

Current Employer _____ Employment Date _____

Street Address _____

City, State, Zip _____

Phone _____

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Are you a Veteran of the US Armed Services? ☐ Yes ☐ No

Guarantor Account Information (Responsible Party for Payment)

Name _____ Social Security # _____ Date of Birth _____

Relationship to Patient _____ ☐ Self

Address _____ ☐ Same as Patient

City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ ☐ Same as Home

Work _____

Insurance Coverage Information (Please provide your insurance card to the front desk)

Insurance Provider Name _____

Subscriber Name _____

Subscriber Relationship to Patient _____ ☐ Self

Member # _____ Group # _____

By signing this application, I affirm under penalty that I have given true and complete information.

_____ _____

Patient Signature Date

_____ _____

Guarantor Signature Relationship to Patient

Campus & Imaging Center ● 2900 NE 132nd Ave, Portland, OR 97230 ● Phone: (503)255-6771 ● Fax: (503)251-5794
East Portland ● 12615 NE Halsey St., Portland, OR 97230 ● Phone: (503)808-7979 ● Fax: (503)808-7988
Gresham ● 1304 NW Civic Drive, Gresham, OR 97030 ● Phone: (503)512-1040 ● Fax: (503)489-0941

(Revised 7/19/18)