Date Completed: _____

MRN: _____

DOB: _____

Main Campus: 3025 S Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551

NEW PATIENT REGISTRATION

(Please write clearly)

DEMOGRAPHICS:

Patient Full Name: _____ DOB: _____
(Last Name) (First Name) (Middle Name)

Other Names Used: _____

What is your preferred first name? (Nickname, Chosen name, etc.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell phone: _____ Email Address: _____

Preferred Contact Phone Number: ☐ Cell ☐ Home ☐ Work

How may we contact you? ☐ Text ☐ Email ☐ Phone ☐ Postal Mail

May we leave confidential voicemail messages on your phone? ☐ Yes ☐ No

SSN: _____ (For your identity privacy at NUNM and is used solely for that purpose)

The following information you provide us helps to serve you and members of the community.

What was your assigned sex at birth? ☐ Male ☐ Female Other (specify) _____

What gender do you identify as? ☐ Male ☐ Female Other (specify) _____

What pronoun do you use? ☐ He/Him/His ☐ She/Her/Hers Other (specify) _____

Interpreter needed? ☐ Yes ☐ No Primary Language: _____

Homeless Status? ☐ Not Homeless ☐ Homeless ☐ At Risk ☐ Transitional Housing ☐ Living in Shelter

Seasonal or Migrant Worker? ☐ Seasonal ☐ Migrant ☐ Neither

Ethnic Group (Select One): ☐ Hispanic ☐ Non-Hispanic ☐ Other _____

Race (Select all that apply): ☐ Asian ☐ Black ☐ White ☐ Alaskan Native ☐ Pacific Islander
☐ American Indian ☐ Other _____

Are you a US Veteran? ☐ Yes ☐ No

Occupation: _____Hours per Week: _____ Employer: _____

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

Date Completed: _____

MRN: _____

DOB: _____

Main Campus: 3025 S Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551

NEW PATIENT REGISTRATION (CONTINUED)

PRIMARY CARE PROVIDER: *(Please select one of the following):*

☐ 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.

**Please Note: Some services provided by NUNM require that the patient be established with a PCP. These services include any specialty service, including, but not limited to cancer care, IV therapy, physical medicine, and homeopathy.*

OTHER PROVIDERS (SPECIALISTS):

_____

_____

EMERGENCY CONTACT: *(The person NUNM will call in the event of an emergency)*

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Legal Guardian? ☐ Yes ☐ No

GUARANTOR: *(The person who is financially responsible for the account):*

Name: _____ Relationship to the patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Gender: ☐ M ☐ F ☐ Other DOB: _____

Guarantor Primary Language: _____ Phone: _____

INSURANCE: *(Please provide your insurance information below)*

The NUNM Health Centers Billing Department requires that ***all*** insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit. **Please be prepared to present your insurance card at check-in for each visit.**

Insurance Company: _____

Claims Address: _____

Subscriber Name (if other than patient): _____ DOB:_____

Date Completed: _____

MRN: _____

DOB: _____

Main Campus: 3025 S Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551
Member ID#: _____ Group #: _____ Subscriber ID #: _____

Although NUNM is not contracted with Medicare, it is our policy to collect all coverage information

Do you have Medicare? □ Yes □ No If "yes", is it your primary insurance? □ Yes □ No
Medicare Plan (check all that apply): □ Part A □ Part B □ Advantage (Part C)

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

OPTIONAL: *I authorize the following individual(s) to arrange appointments at NUNM on my behalf*:

Name: _____ Name: _____
DOB: _____ DOB: _____
Relationship to Patient: _____ Relationship to Patient: _____

AUTHORIZATION: *I certify the above information is true and correct to the best of my knowledge.*

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

Thank you for completing this form. Please also take a moment to acknowledge your rights and responsibilities as a patient of NUNM health centers.

Patient Rights & Responsibilities

The full documentation of NUNM's Patient Rights and Responsibilities is available for review in the health centers lobby or by request to the front desk. You may also request a copy for your records.

AUTHORIZATION: *I certify that I have reviewed and understand my patient rights and responsibilities.*

_____ _____
Signature of Patient, Parent, or Legal Guardian Date