NUNM HEALTH CENTERS

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

NEW PATIENT REGISTRATION

(In order to ensure the accuracy of your information; please write clearly if filling in the form manually)

DEMOGRAPHICS:

Patient Full Name: ______________________________ Birth Date: ______________
(First) *(Middle)* *(Last)*

Other Names Used: ______________________________

What is your preferred first name? (*Chosen name, nickname, etc.*) ______________________________

Address: ______________________________

City: ______________________ State: ____________ Zip Code: ______________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Email Address: ______________________

Preferred Contact Phone Number? *(Select one)*: ☐ Home ☐ Work ☐ Cell

How may we contact you? *(Select all that apply)*: ☐ Postal Mail ☐ Phone ☐ Email ☐ Text

May we leave you confidential voicemail messages? ☐ Yes ☐ No

Social Security Number: ______________________ *(used only for identity verification and privacy)*

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.**

****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): ______________________

Primary (Alternate) 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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NEW PATIENT REGISTRATION (CONTINUED)

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: _________________________ Birth date: ___________________

Guarantor Primary Language: _______________________________ Phone: ______________________________________

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

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

Name: ____ Name: ____

Birth date: _____________________________________ Birth date: _____________________________________

Relationship to Patient: __________________________ Relationship to Patient: __________________________

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):

____

____

____

____

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NEW PATIENT REGISTRATION (CONTINUED)

Please select all answers that apply. Use the self-describe field to note an answer that didn't have the best option present.

What was your assigned sex at birth? ☐ Female ☐ Male ☐ *(self-describe)* ____________________
What is your current legal sex? ☐ Female ☐ Male ☐ X (Only alternative accepted in Oregon)
What is your current gender identity? ☐ Female ☐ Male ☐ *(self-describe)* ____________________
Which pronoun(s) do you use? ☐ She/Her/Hers ☐ He/Him/His ☐ They/them/their
☐ *(self-describe)* ____________________

Interpreter Needed? ☐ Yes ☐ No Primary Language: ________________________________

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

Migrant or Seasonal Worker? ☐ Migrant ☐ Seasonal ☐ Neither

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

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

AUTHORIZATION: *(Please sign and date below)*

- *I also 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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NEW PATIENT REGISTRATION (CONTINUED)

To expedite your paperwork and scheduling, please attach/bring the following documents:

A phone photo or digital scan will work. If this is not possible, please text images of your ID and insurance cards to #503-552-1551. Otherwise, we will collect this information at your first check-in.

Please be sure to bring your photo ID and all insurance cards to each visit at NUNM. Please upload any and all cards you currently possess.

Photo ID Front: ____________________ Photo ID Back: ____________________

Medicaid Card Front: __________________ Medicaid Card Back: ____________________

Primary Insurance Front: _______________ Primary Insurance Back: ____________________

Secondary Insurance Front: _____________ Secondary Insurance Back: ___________________

Once this form is completed, you will be redirected to our website and other forms that will be beneficial to complete ahead of your first appointment. This includes our consent forms and health history forms. Please give us up to 10 business days to complete processing your registration form, we will contact you as soon as we are ready to schedule your appointment.

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 at the front desk. You can also review a copy online at: https://nunmhealthcenters.com/new-patients/.
You may also request a copy for your records.

When this form is submitted, you will receive a PDF copy in your email.

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HEALTH HISTORY

____ ____________________
First Name Middle Last Name Date of Birth

What is the reason(s) for your visit to our Health Center today?

Primary concern: ____

Secondary concern: ____

Additional concern: ____

Additional concern: ____

> ****Please note that we may not be able to address all of your concerns in a single visit. We will address concerns as visit time allows in order of medical priority. Follow-up visits may be needed to address additional concerns.***

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: Do you have any allergies to the following? *(Please select all that apply)*

☐ Aspirin	☐ Bees	☐ Cats	☐ Codeine	☐ Contrast Dye	☐ Dogs
☐ Eggs	☐ Fish	☐ Latex	☐ Lidocaine	☐ Milk	☐ Mold
☐ Morphine	☐ NSAIDS	☐ Peanuts	☐ Penicillin	☐ Pollen	☐ Shellfish
☐ Soy	☐ Sulfa	☐ Sulfites	☐ Tetracycline	☐ Wheat	

☐ Other ____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking:

Name of Medication/Supplement	Strength	Frequency Taken and Route (oral, topical, etc.)	How long have you been taking this?

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Medical Conditions: Do you currently have or have a history of the following? *(Please select all that apply)*

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

Surgeries / Hospitalizations: Have you had any of the following surgeries? *(Please select all that apply and indicate the month and year, MM/YY)*

- ☐ Appendectomy, Date: _________
- ☐ Brain Surgery, Date: ___________
- ☐ Breast Surgery, Date: __________
- ☐ CABG, Date: _________________
- ☐ Cholecystectomy, Date: _______
- ☐ Colon Surgery, Date: __________
- ☐ Cosmetic Surgery, Date: _______
- ☐ C-Section, Date: _______________
- ☐ Eye Surgery, Date: _____________
- ☐ Fracture Surgery, Date: _________
- ☐ Hernia Repair, Date: ____________
- ☐ Hysterectomy, Full, Date: ________
- ☐ Joint Replacement, Date: ________
- ☐ Prostate Surgery, Date: __________
- ☐ Small Intestine Surgery, Date: _______
- ☐ Spine Surgery, Date: ______________
- ☐ Tonsillectomy, Date: ______________
- ☐ Tubal Ligation, Full, Date: __________
- ☐ Valve Replacement, Date: __________
- ☐ Vasectomy, Date: _________________
- ☐ Other: _______________, Date: ______

Do you have any implants, artificial joints or discs, metal or anything that could impact therapy or imaging? ☐ Yes ☐ No

If YES, please describe: ____

Family History: Do you have a family history of any of the following? *(Please "X" the boxes that apply to you)*

	Alcohol/ Drug Addiction	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	High Blood Pressure	Kidney Disease	Mental Illness	Stroke	Vision Problems	Gastrointestinal	Other
Mom															
Dad															
Sister															
Brother															
Mom's Mom															
Mom's Dad															
Dad's Mom															
Dad's Dad															
Mom's Sister															
Mom's Brother															
Dad's Sister															
Dad's Brother															

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Immunization History: *(Please select all that apply)*

Did you complete your childhood vaccinations? ☐ Yes ☐ No
Have you had a tetanus titer 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

Social History: Do you use any of the following tobacco products? *(Please select all that apply)*

Do you use tobacco products? ☐ Yes ☐ No
Smoking History:
☐ Current Every Day Smoker ☐ Current Smoker, Some Days ☐ Former Smoker ☐ Heavy Tobacco Smoker
☐ Light Tobacco Smoker ☐ Never Smoker ☐ Passive Smoke Exposure – Never Smoker
☐ Other: _____________________

Type of Tobacco Used: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ Chew ☐ Other: ______________

Start Date: ____ Quit Date: _______________________________________
Packs per day: ___ Years of smoking: ___ **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
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 or street drugs? *(Please select all that apply)*

☐ E-Cigs ☐ Nicotine Vaping ☐ Marijuana ☐ Opioids ☐ Heroin
☐ Meth ☐ Amphetamines ☐ PCP ☐ Ecstasy ☐ LSD
☐ Ketamine ☐ Mescaline ☐ Psilocybin/ Psychedelics ☐ Cocaine ☐ Crack
☐ Nitrous Oxide ☐ Solvent Inhalants ☐ Barbiturates ☐ Benzodiazepines ☐ IV
☐ Other: ____

Sexual Orientation and Gender Identity: *(Please select all that apply)*

Do you think of yourself as: ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual
☐ *(self describe)*:___________________ ☐ Don't know ☐ Choose not to disclose

What is your gender identity? *(Please select all that apply)*
☐ Cisgender Female ☐ Cisgender Male
☐ Transgender Female/ Trans Woman/ Male-to-Female (MTF) ☐ Transgender Male/ Trans Man/ Female-to-Male (FTM)
☐ Additional Gender Category or Other Not Listed ☐ Choose not to disclose

Are you sexually active? ☐ Yes ☐ No ☐ Not Currently

Partners? *(Please select all that apply)* ☐ Female ☐ Male ☐ (*self describe*): ___________________

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What is your current birth control method? (Please check all that apply):

☐ Abstinence	☐ Cervical Cap	☐ Condom	☐ Diaphragm
☐ Hormonal Patch	☐ Implant	☐ Injection	☐ Inserts
☐ IUD	☐ IUS	☐ Pill	☐ Rhythm
☐ Spermicide	☐ Sponge	☐ Surgical	☐ Vaginal Ring
☐ Withdrawal	☐ Vasectomy	☐ Menopause	☐ None

☐ Other: ____

PHQ-2: Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things	☐ nearly every day ☐ more than half the days	☐ several days ☐ not at all
2. 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 'C' for any current symptoms *(in the past 2 weeks)*. Please mark 'P' if you are not currently experiencing the symptom. *If you have had any one of these symptoms in the past, it will be captured in the history sections above.*

Constitution

Fever	☐ C	☐ P	Chills	☐ C	☐ P	Weight Loss	☐ C	☐ P
Fatigue	☐ C	☐ P	Sweating	☐ C	☐ P	Weakness	☐ C	☐ P

Skin

Rash	☐ C	☐ P	Itching	☐ C	☐ P	Other: ___________________

Head, Ears, Nose, Throat

Hearing Loss	☐ C	☐ P	Ringing in Ears	☐ C	☐ P	Ear Pain	☐ C	☐ P
Ear Discharge	☐ C	☐ P	Nosebleeds	☐ C	☐ P	Congestion	☐ C	☐ P
Sinus Pain	☐ C	☐ P	Noisy Breathing	☐ C	☐ P	Sore Throat	☐ C	☐ P

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Review of Systems *(Continued):* Please mark 'C' for any current symptoms *(in the past 2 weeks)*. Please mark 'P' if you are not currently experiencing the symptom. *If you have had any one of these symptoms in the past, it will be captured in the history sections above.*

Eyes

Blurred Vision	☐ C	☐ P	Double Vision	☐ C	☐ P	Light Sensitivity	☐ C	☐ P
Eye Pain	☐ C	☐ P	Eye Discharge	☐ C	☐ P	Eye Redness	☐ C	☐ P

Cardiovascular

Chest Pain	☐ C	☐ P	Palpitations	☐ C	☐ P	Shortness of breath Lying down	☐ C	☐ P
Leg Cramping/ Claudication	☐ C	☐ P	Leg Swelling	☐ C	☐ P	PND	☐ C	☐ P

Respiratory

Cough	☐ C	☐ P	Coughing up Blood	☐ C	☐ P	Sputum Production	☐ C	☐ P
Shortness of breath	☐ C	☐ P	Wheezing	☐ C	☐ P		☐ C	☐ P

Gastrointestinal

Heartburn	☐ C	☐ P	Nausea	☐ C	☐ P	Vomiting	☐ C	☐ P
Abdominal Pain	☐ C	☐ P	Diarrhea	☐ C	☐ P	Constipation	☐ C	☐ P
Blood in Stool	☐ C	☐ P	Black/Tarry Stools	☐ C	☐ P			

Genitourinary

Painful Urination	☐ C	☐ P	Urgency	☐ C	☐ P	Frequency	☐ C	☐ P
Blood in Urine	☐ C	☐ P	Flank/Side Pain	☐ C	☐ P			

Male Sexed

Hernias	☐ C	☐ P	Testicular Masses	☐ C	☐ P	Sexual Difficulty	☐ C	☐ P

Female Sexed

Age of first menses	____________	Age of last menses	____________	Duration of menses	____________
Date of last annual exam	____________	Number of pregnancies	____________	Number of live births	____________
Number of miscarriages	____________	Number of abortions	____________		

Musculoskeletal

Muscle Pain	☐ C	☐ P	Neck Pain	☐ C	☐ P	Back Pain	☐ C	☐ P
Joint Pain	☐ C	☐ P	Falls	☐ C	☐ P			

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Review of Systems *(Continued):* Please mark 'C' for any current symptoms *(in the past 2 weeks)*. Please mark 'P' if you are not currently experiencing the symptom. *If you have had any one of these symptoms in the past, it will be captured in the history sections above.*

Endocrine/ Heme/ Allergies

Easy Bruising/ Bleeding	☐ C	☐ P	Env. Allergies	☐ C	☐ P	Excessive Thirst	☐ C	☐ P

Neurological

Dizziness	☐ C	☐ P	Headaches	☐ C	☐ P	Tingling	☐ C	☐ P
Tremor	☐ C	☐ P	Sensory Change	☐ C	☐ P	Speech Change	☐ C	☐ P
Focal Weakness	☐ C	☐ P	Seizures	☐ C	☐ P	Fainting	☐ C	☐ P

Psychiatric

Depression	☐ C	☐ P	Suicidal Ideas	☐ C	☐ P	Substance Abuse	☐ C	☐ P
Hallucinations	☐ C	☐ P	Nervous/ Anxious	☐ C	☐ P	Insomnia	☐ C	☐ P
Memory Loss	☐ C	☐ P						