Connected Whole Health
at University of Western States
8000 NE Tillamook Street | Portland, OR 97213 | Suite A
Phone: 503-808-7979 | Fax: 503-808-7988
uwsconnectedhealth.com

# NEW PATIENT REGISTRATION

**Patient Information**

Full Legal Name: _____

Preferred Name: _____

Social Security # _____ Date of Birth _____

Legal Sex: ☐ Female ☐ Male ☐ Please Specify _____ ☐ Choose Not to Disclose

Gender Identity: ☐ Female ☐ Male ☐ Please Specify _____ ☐ Choose Not to Disclose

Pronoun(s): ☐ she/her/hers ☐ he/him/his ☐ Please Specify _____ ☐ Choose Not to Disclose

Street Address _____

City _____ State _____ Zip _____

Billing Address _____ ☐ Same as Street

City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ Work _____

Email Address _____

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

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 ☐ American Indian ☐ Asian ☐ Black/African American ☐ Cape Verdean ☐ Costa Rican ☐ Dominican ☐ Honduran ☐ Liberian ☐ Native Hawaiian ☐ Pacific Islander ☐ Trinidadian ☐ Wampanoag ☐ White ☐ Unknown ☐ Choose Not to disclose

Primary Language (if not English) _____ Do you need an interpreter? ☐ Yes ☐ No

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

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**Emergency Contact Information**

Emergency Contact _____ Relationship _____

Emergency Phone (Home) _____ (Work) _____

**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 _____ Work _____

Email Address _____

**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