White Bird Medical Clinic

NEW PATIENT INTAKE FORM

Today's Date: ___/___/_____

Name:	Social Security Number:	Date of Birth:
	- -	/ /

Phone:	Address:	City:	State:	ZIP:
( ) -				

☐ Cell ☐ Home ☐ Public ☐ Other ---------- May we leave messages: ☐ YES ☐ NO

Marital Status:
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Annulled
☐ Life Partner ☐ Decline to Specify
☐ Other: ______________

Student Status: ☐ Full Time Student
☐ Part time Student ☐ Not a Student

Smoker/Tobacco User: ☐ Yes ☐ No

Veteran: ☐ Yes ☐ No

Previous Name (if any): ___________________________

Email Address: ___________________________________

Would you like to enroll in our Patient Portal Program? ☐ Yes ☐ No

Race (please check all which may apply):
☐ White ☐ Black/African American ☐ Native American/Alaskan Native
☐ Asian ☐ Indian ☐ Pacific Islander ☐ Decline to Specify

Hispanic/Latino: ☐ Yes ☐ No ☐ Decline to Specify

Living situation:
☐ Rent
☐ Own
☐ Shelter
☐ Transitional housing
☐ Street/car
☐ Staying with friends/family
If so, how long? _______________

Birth Sex: ☐ Male ☐ Female ☐ Intersex

Gender Identity: ☐ Male ☐ Female ☐ M-F Trans ☐ F-M Trans
☐ Non-binary ☐ Decline to Specify ☐ Something Else: ______________

Sexual Orientation: ☐ Straight ☐ Gay/Lesbian ☐ Bisexual
☐ Decline to Specify ☐ Something Else: ________________

Pronouns: ☐ He, him, his ☐ She, her, hers ☐ They, them, theirs
☐ Zee, Hir ☐ Declined to Specify ☐Something Else: _______________

Insurance Info (check all that apply)

Medicaid (OHP)
☐ Trillium
☐ D-MAP/open card
☐ Non-Lane County OHP

Medicare
☐ Part A
☐ Part B
☐ Part D
☐ Advantage*

☐ No Insurance
☐ Private Insurance*
____

Income Info:

Monthly Income: ___________

Family Size: _______

Preferred Pharmacy:

*WBMC does not currently accept private insurance - incl. Medicare Advantage

Emergency Contacts (if any):

Name (first and last)	Relationship	Phone Number	Date Of Birth

WBMC IS NOT CURRENTLY ACCEPTING NEW PATIENTS WHO REQUIRE CONTINUATION OF CONTROLLED SUBSTANCE PRESCRIPTIONS INCLUDING: NARCOTICS (VICODIN, OXYCONTIN, ETC.), BENZODIAZEPINES (KLONOPIN, XANAX, ATIVAN,TEC.), OR AMPHETAMINES (ADDERALL, RITALIN, ETC.).

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Today's Date:

___/___/_____

TODAY'S VISIT

Please check the most important issue you would like to discuss today:

☐ Establish care	☐ Out of medication	☐ Feeling sick
☐ Recently injured	☐ Hospital follow-up	☐ Mental/emotional health

Please describe the issue:	**How long have you had this issue?**

Previous care received for this issue (if any):
(include other doctors, urgent care, ER visits)

MEDICAL INFORMATION

Do you currently have a Primary Care Provider? ☐ YES ☐ NO		**List any known diagnosed conditions:** (such as high blood pressure, diabetes, depression)
Previous provider name:	**Clinic name:**	
Last seen:	**Reason for leaving:**	**List all current medications:**
Are you having difficulty finding resources (food, clothing, transportation, etc.)?	☐ YES ☐ NO	
Do you need help applying for benefits (OHP, Food Stamps, etc.)?	☐ YES ☐ NO	

OFFICE USE ONLY

☐ ACUTE ONLY ☐ WISH TO ESTABLISH CARE ☐ MEDICAL HOME

RECEIVED APPT: ☐ Same Day ☐ < 1 week (w/in 1 week) ☐ > 1 week

NOT SEEN: ☐ Referred to ER/ Urgent Care ☐ Referred to Clinic/ Specialty/ Resource

☐ Other

SEEN BY: ☐ Staff Physician ☐ Volunteer Provider ☐ Nurse Visit

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