Grant County Health Department
528 E Main St Suite E
John Day, OR 97845

NAME:(Please Print)_____ MALE_____FEMALE___OTHER_

BIRTH DATE:_____MARITAL STATUS: (Circle one) S M D W

RACE: (circle one) (1) American Indian/Alaskan Native (2)Asian (3)Black/African American (4)Hispanic/Latino (5)Native Hawaiian/Pacific Islander (6)White (7) Other

LANGUAGE: (1) English (2) Spanish (3) Other-Specify _____
ETHNICITY: (circle one) (1) Hispanic (2) Non-Hispanic

MAILING ADDRESS:_____

CITY:_____**STATE**:_____**ZIP**:_____

PHONE #:_____ EMAIL_____

*****HOW DO YOU PREFER TO BE CONTACTED: Email, Text, MyChart;**
MAY WE LEAVE A MESSAGE AT THE NUMBERS LISTED: Y___N___****

USUAL DOCTORS:_____PHARMACY:_____

ALLERGIES:_____

VETERAN: **Y____ N_____** NUMBER OF PEOPLE IN HOUSEHOLD_____

GROSS FAMILY INCOME (Monthly income before taxes) _____SOCIAL SECURITY#:_____
We ask for your income information so we can do a sliding fee if you are income eligible

INSURANCE CARRIER:_____

POLICY#:_____ GROUP#_____

NAME, DATE OF BIRTH, SOCIAL SECURITY NUMBER AND CONTACT INFO OF INSURANCE SUBSCRIBER IF DIFFERENT FROM PATIENT_____

SECONDARY INSURANCE:_____POLICY&GROUP #:_____

EMERGENCY CONTACT NAME:_____PHONE #:_____

HOUSEHOLD MEMBERS:

NAME	SEX	RELATIONSHIP	BIRTH DATE

*****ALL INFORMATION IS HELD IN STRICT CONFIDENTIALITY*****