UMPQUA COMMUNITY HEALTH CENTER

Pediatric Patient Data Sheet

Patient's Name: _____Middle: _____Last: _____
Sex: Male Female Date of Birth: _____Age: _____Patient's SSN: _____
Mailing Address: _____City: _____Zip: _____
Physical Address: (Must have in case of emergency) _____
Mother's Name: _____Phone: _____
Father's Name _____Phone: _____
Who does the child primarily live with? _____
Who has legal guardianship of child? _____Phone: _____

Primary Insurance: If you do not present your insurance card at appointment or by 10 days following your appointment, you will be billed for all charges. We will not go back at a later date and back bill your charges.

Oregon Health Plan: Open card Advantage Dental Recipient ID number: _____
Dental Insurance: _____
Policy Holder: _____Relation to patient: _____
ID# _____Group #_____Employer: _____
Dental secondary Insurance: _____
Policy Holder: _____Relation to patient: _____
ID# _____Group #: _____Employer: _____

The following information is needed to assist the clinic in securing funds to operate and is reported anonymously. Your co-operation will be appreciated.

Have you been seen at the VA? Yes No
US citizenship: By Birth Permanent Resident/Alien Student Visa Other
Race: Black White Asian American Indian Pacific Islander Hawaiian Other Unreported
Ethnicity: Hispanic No-Hispanic Choose not to disclose
Language Spoken: _____ Do you need a translator? Yes No
Are you: 1) a single parent? Yes No 2) Homeless? Yes No 3) Resident of public housing? Yes, No
Gender Identity: Male Female Transgender Male Transgender Female Other Choose not to disclose
Sexual Orientation: Straight Lesbian/Gay Bisexual Other Don't know Choose not to disclose

Please check only one amount, based on your income and family size

Number of Persons in Household	1	2	3	4	5	6
Monthly Household Income is Less Than	o1,005	o1,353	o1,702	o2,050	o2,398	o2,747
Monthly Household income is Less Than	o1,337	o1,800	o2,263	o2,727	o3,190	o3,653
Monthly Household income is Less Than	o2,010	o2,707	o3,403	o4,100	o4,797	o5,493
Monthly Income is above all amounts	o	o	o	o	o	o

o **Choose not to disclose financial information**

Records Release: I hereby authorize release of this record to my industrial carrier and/or my personal or referral dental or healthcare provider. _____**Please initial**

Signature of patient or legal guardian Date:

Intake initials/date_____ Entry initials/date: _____