Connected Whole Health
at University of Western States

8000 NE Tillamook St ▪ Portland, OR 97213
Phone: 503-255-6771 ▪ Fax: 503-251-5794

NEW PATIENT REGISTRATION

Legal Name- First, Middle and Last: _____

Preferred Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Occupation: _____ Work Phone: _____

How did you hear about our clinic? _____

Primary Language (if not English)_____Do you need an interpreter? ☐ Yes ☐ No
Communication Preference: ☐ MyChart ☐ Phone ☐ Email ☐Mail ☐ No Preference ☐ Do Not Contact

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex ☐ Choose Not to Disclose
Gender Identity: ☐ Female ☐ Male ☐ Non-Binary ☐ Other_____ ☐ Choose not to disclose
Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other (Please Specify) _____
☐ Choose Not to Disclose

Ethnicity: ☐ Hispanic ☐ non-Hispanic ☐ Unknown
Race (check all that apply): ☐ Alaskan Native ☐ American Indian ☐ Asian Indian ☐ Black/African American
☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Other Asian
☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Unknown ☐ Choose Not to disclose.

Emergency Contact _____ Relationship _____
Emergency Phone (Home) _____ (Work) _____
Primary Language (if not English)_____Do they need an interpreter? ☐ Yes ☐ No

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

By signing this application, I affirm under penalty that I have given true and complete information.

_____ _____
Patient Signature Date

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If patient is under the age of 18, please complete the following **Guarantor** section:

Legal Name- First, Middle and Last: _____

Preferred Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Relationship to Patient_____

Primary Language (if not English)_____Do they need an interpreter? ☐ Yes ☐ No

_____

Guarantor Signature (Required if patient is under age 15)

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Welcome to Connected Whole Health. Please fill out both sides of this form. The information you provide will help your physician determine the best care for you. All information will be kept strictly confidential.

Name _____ **DOB** _____ **Today's Date** _____

Legal Name (if different from above) _____

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

Preferences for Care: ☐ Female Provider/Intern ☐ Male Provider/Intern ☐ No preference ☐ For religious reasons ☐ Other reasons

Chief Complaint:

List your current health concerns	How long have you had this condition?

Hospitalizations/Surgeries:

When	For what condition?	Do you have any residual effects?

Medications: (prescription, over the counter supplements, etc.)

Medication	Dose	For what condition?

Allergies: (medications, environmental, foods, etc.)

What are you allergic to?	What is your reaction?

Past Medical History: Have you ever had any of the following conditions (**circle all that apply**)?

Allergies	Anemia	Anxiety
Arthritis/joint pain/joint stiffness	Asthma	Blood transfusion
Cancer	Cataracts	CHF
Clotting disorder	COPD	Depression
Diabetes	Emphysema	GERD/Heartburn
Glaucoma	Heart murmur	HIV/AIDS
Hypertension	Kidney disease	Meningitis
Heart attack	Nerve or muscle disease	Osteoporosis
Seizure	Sickle cell anemia	Stroke
Substance abuse	Thyroid condition	Tuberculosis
Ulcers	Other:	

Past Surgical History: Have you ever had any of the following surgeries (**circle all that apply**)?

Appendectomy	C-Section	Prostate surgery
Brain surgery	Eye surgery	Small intestine surgery
Breast surgery	Fracture surgery	Spine surgery
CABG	Hernia repair	Tubal ligation
Cholecystectomy	Hysterectomy	Valve replacement
Colon surgery	Joint replacement	Vasectomy
Cosmetic surgery	Trans specific surgeries	Other:

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Family Health History: Were you adopted? □ Yes

Relative	Age	Disease(s)	Age at Onset	If deceased (cause of death)
Parent 1				
Parent 2				
Grandparent 1				
Grandparent 2				
Grandparent 3				
Grandparent 4				
Your sibling (s)				
Your children				

Do you exercise? □ Yes □ No

What type of exercise?	How long and how often do you exercise (e.g. 3x/wk/30 min)

Do you drink alcohol? □ Yes □ No

What type of alcohol?	# of drinks per week
Glasses of wine	
Cans / bottles of beer	
Shots of liquor	
Drinks containing 0.5 oz alcohol	

Have you ever used Tobacco? □Yes □No **Currently Using** □Yes □No **How long** _____ **Quit date** _____

What type of tobacco?	Amount of use per day
Cigarettes	
Vape	
Other:	
Are you interested in quitting? □ Yes □ No	

Do you use non-prescription drugs? (e.g. marijuana, ecstasy, psilocybin, etc.) □ Yes □ No
If Yes, will you share what type and how frequently? _____

Are you sexually active? □ Yes □ No
Do you have a need for birth control? □ Yes □ No
What type of birth control / protection do you use?: Abstinence, cervical cap, condom, diaphragm, Hormone patch, implant, injection, inserts, IUD, IUS, Pill, rhythm, spermicide, sponge, surgical, vaginal ring, withdrawal, none.

We ask all patients about safety in relationships because it can affect health. Do you feel safe in your current relationship or at home? □ Yes □ No □ I'm not sure If you would like to talk privately or need help, please let us know here: _____

We strive to create a welcoming environment for all our patients. The following questions are available if you wish to share more about yourself with our clinical team. You can also choose not to disclose.

Gender Identification: ☐ Female ☐ Male ☐ Nonbinary ☐ Trans Female ☐ Trans Male ☐ Intersex ☐ Choose not to disclose
☐ Other: Please Specify _____

Sexual Orientation: ☐ Gay ☐ Heterosexual ☐ Bisexual ☐ Pansexual ☐ Asexual ☐ Queer ☐ Choose not to disclose
☐ Other: Please Specify _____

Are you a person with (check all that apply)?: ☐ Breasts ☐ Cervix ☐ Uterus ☐ Vagina ☐ Penis ☐ Prostate ☐ Testes
☐ Intersex genitalia ☐ Genital reassignment surgery(s) ☐ Do not know ☐ Choose not to disclose

Is there anything else we can help you with or you'd like to tell us that we haven't addressed on this form?

_____
_____
_____

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

A patient and/or the patient's legal representative has the right to:

- Receive complete and current information and answers to questions about diagnosis, treatment and prognosis.
- Participate in decisions about care and provide informed consent for procedures.
- Refuse treatment and accept potential consequences of that decision.
- Receive considerate and respectful care in an environment that permits reasonable privacy.
- Know the identity and professional status of individuals providing service and know who has primary responsibility for coordinating care.
- Have another person present during examination and/or treatment.
- Expect reasonable safety within the health care environment.
- Be fully advised of and accept or refuse to participate in any research project and/or experimental procedures.
- Expect that all communications and records pertaining to care will be subject to appropriate confidentiality.
- Examine and receive an explanation in advance of any charges for services rendered.
- Expect not to be denied care solely based on race, sex, national origin, religion, gender identity, or sexual orientation.
- Express grievances regarding any perceived violation of rights to the institution and to appropriate regulatory agencies.

Patient Responsibilities

A patient and/or the patient's legal representative have the responsibility to:

- Provide accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, and any other matters related to their health.
- Report in a timely manner any new incident, trauma, or changes in health condition.
- Acknowledge and consider instructions and recommendations provided by health care providers and/or office staff.
- Request clarification about any aspect of care not fully understood.
- Assure that the financial obligations related to their health care are fulfilled as promptly as possible.
- Treat members of the health care community with respect and courtesy. Inappropriate comments or behavior that may be construed as sexist, racist or otherwise demeaning are not tolerated and will result in a warning or possible discharge of care. Flirting with staff or students, inappropriate touch and or sexual harassment will lead to discharge of care and potential legal involvement.

CANCELLATION POLICY: We require 48 hours' notice for cancellations. This policy helps ensure that the open appointment will be filled with another patient. **After 3 same day cancellations and/or no-shows, you will enter a probationary period of 6 months before you can schedule again.**

I acknowledge that I understand and agree to follow these patient rights and responsibilities.

Printed Name: _____ **Date:** _____

Signature: _____

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FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. TO ACHIEVE THIS, WE REQUEST YOU CAREFULLY READ AND UNDERSTAND OUR FINANCIAL POLICY. PATIENTS ARE RESPONSIBLE FOR ANY CHARGES NOT INCLUDED AS COMPLIMENTARY CARE AT THE TIME OF SERVICE.

1) **As a teaching clinic, we currently offer our patients complimentary health care services** including exams, consultations and treatment. If X-ray imaging is clinically indicated and ordered during your examination with us, it will be provided at no cost.

2) **Additional items are not complimentary and are priced individually.** You will be made aware of the fees for products in advance of any charges

3) **Payment is due upon receipt of these items. We accept credit/debit cards and checks.** We are unable to accept cash payments as of April 1st 2025.

4) **Our providers are not in network with Medicare.**

    a. **Our chiropractors are unable to treat patients enrolled in Medicare.** By signing this form, you attest that you are not now, nor will you be enrolled in Medicare part B and/or C while you are seeking chiropractic services with Connected Whole Health. Further, you agree to terminate in the event the prior statement becomes untrue.
    b. **Our naturopathic physicians can treat Medicare patients**. Medicare does not pay for services provided by naturopathic physicians. Therefore, all services that we deliver here in our office are excluded by Medicare because they are ordered or rendered by a Doctor of Naturopathic Medicine.

5) **We do not bill insurance and will not file any claims on your behalf**. This includes worker's compensation and motor vehicle claims. If you have been personally injured at work or in a motor vehicle accident, we will be happy to work with you. Be advised, however, that you will be charged $0.00 for exams and treatments which may affect the potential total settlement amount of your claim. We advise that you consult with your attorney to determine if our clinic is the right fit for your claim.

I have read, understand and agree with the above financial policy.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____

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