995 Willagellespie Road, Suite 100
Eugene, OR 97401-2186
Phone 541-246-7263
Fax 541-343-7360

Patient Registration Form

Note: Only one Guarantor per patient (who is financially responsible?)

DATE:_____

Parent #1:_____ Date of Birth: _____ Male ☐ Female ☐
Last First Middle

Relationship to Patient: Mother ☐ Father ☐ Step-Parent ☐ Domestic Partner ☐ Guarantor ☐ Other: _____

Marital Status: M ☐ S ☐ D ☐ W ☐ SS#:_____ **Email:** _____

Street Address:_____ **Home Phone**:_____

City: _____State: _____Zip: _____ **Cell Phone**:_____

Employer:_____Occupation: _____ Work Phone: _____

Parent #2:_____ Date of Birth: _____ Male ☐ Female ☐
Last First Middle

Relationship to Patient: Mother ☐ Father ☐ Step-Parent ☐ Domestic Partner ☐ Guarantor ☐ Other: _____

Marital Status: M ☐ S ☐ D ☐ W ☐ SS#:_____ **Email:** _____

Street Address:_____ **Home Phone**:_____

City: _____State: _____Zip: _____ **Cell Phone**:_____

Employer:_____Occupation: _____ Work Phone _____

1. **Patient** :_____ Date of Birth: _____ Sex: M ☐ F ☐ Age:_____
Last First Middle

Lives with: ☐ Father ☐ Mother ☐ Both ☐ Other: _____

Race (Please circle one) Hispanic - Asian - Caucasian - African American - American Indian - Alaska Native - Pacific Islander - Filipino - Other:_____

Primary Language (please circle one) English – Spanish – French – Italian – German – Mandarin – other _____

Ethnicity (Please circle one) Hispanic or Latino - NonHispanic or Latino - Other or Undetermined

Primary Insurance: _____ ID# _____ Group #: _____
Subscriber: ☐ Father ☐ Mother ☐ Other:_____
Secondary Insurance: _____ ID# _____ Group #: _____
Subscriber: ☐ Father ☐ Mother ☐ Other:_____

Other than parents, I authorize the following people to obtain medical treatment for my child(ren):

_____
Name Relationship to Patient Phone

I have received, read, and understand Thrive Behavioral Health's Privacy and Financial Policies:

_____
Name Relationship to Patient Phone