O

QUEST CENTER FOR INTEGRATIVE HEALTH

Agency Registration Form

Today's Date: ____________________

Basic Info: ***While Quest recognizes a spectrum of gender/sex, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex on record with your insurance company must be used on documents pertaining to insurance and billing. However, please also let us know the gender, name, and pronouns that you would like us to use.***

____

Legal Last Name | Legal First Name | MI | Preferred Name | Date of Birth

____

Street Address | Unit/Apt # | City | State | Zip

County: ______________________ Housing Status: ☐ Permanent ☐ Temporary ☐ Houseless ☐ Other: _____________

Gender Identity: ☐ Female ☐ Genderqueer/Non-Binary ☐ Trans ☐ Male ☐ Other:____________________________

Legal gender: ☐ Female ☐ Male ☐ Intersex Pronoun: ☐ She ☐ He ☐ They ☐ Other: ___________________

Contact Info:

Phone Number:	Cell:	Work:	Home:
Messages OK?	Yes / No	Yes / No	Yes / No

Email: _____________________________________ Appointment Reminders via: ☐ Phone ☐ E-mail ☐ None

Would you like to receive Quest's Electronic Newsletter? ☐ Yes ☐ No

Billing Information:

Insurance: ☐ Medicaid/OHP ☐ Medicare ☐ VA ☐ IHS ☐ Self-Pay ☐ Uninsured ☐ Private:____________________

_____________________________ _____________________________ _____________________________

Primary Insurance Carrier | Insurance ID Number | Secondary Insurance Carrier, if applicable

_____________________________ _____________________________ _____________________________

Policy Holder's Name (If not you) | Policy Holder's Date of Birth | Relationship to You

Demographics: *Your optional responses help Quest develop culturally responsive and inclusive programs. As a Non-Profit, we collect this data in order to secure funding for marginalized populations, but understand that one's identity can't be reduced to a series of boxes.*

Do you think of yourself as: ☐ Lesbian/Gay ☐ Straight/Hetero ☐ Bi/Pan-sexual ☐ Queer ☐ Asexual ☐ Other

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Poly ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Please choose all options that best describe your racial or ethnic heritage:

☐ Black/African American ☐ White/European ☐ Middle Eastern/North African ☐ Asian:____________________

☐ Native/Indian/Indigenous American: _______________ ☐ Alaska Native/Eskimo ☐ Native Hawaiian/Pacific Islander

☐ Hispanic:______________ Latin American/Latinx/Caribbean ☐ Mexican/Chicanx/Xicanx ☐ Other:________________

Appx. Monthly income? $___________________ How many people (including you) does your income support?________

Military Status: ☐ N/A ☐ Active Duty ☐ Veteran ☐ Discharged ☐ Reserve

For Business Office Use Only:

Primary Location: ☐ Multnomah ☐ Clackamas

Program of Entry: ☐ Mental Health ☐ FSR ☐ Ryan White Mental Health ☐ HIV Peer Support ☐ Acupuncture
☐ Women of Wisdom (WOW) ☐ WISH Pain Management ☐ Naturopathy ☐ Osteopathy

Ind. Entering Data:_________________________ Date Entered:_____________________

O

QUEST CENTER
FOR INTEGRATIVE HEALTH

Agency Registration Form

Today's Date: ____________________

Are you a: ☐ New Quest client? ☐ Returning Client? *__Name & Agency of Referral Source:__________________________

How did you hear about us?: ☐ Quest Client/Provider ☐ Other Healthcare Provider ☐ Social Service Provider
☐ Insurance Company ☐ Ad/Brochure ☐ Quest Website ☐ Social Media/Facebook ☐ Other:______________

Emergency Contact Name | Relationship to you | Phone | Alt. Phone

Street Address | Unit/Apt # | City | State | Zip Code

Medical Provider Information:

Primary Care Physician | Medical Center | Location | Phone

Preferred Hospital | Location | Preferred Pharmacy

Sexual Health & Wellness:

Current HIV Status: ☐ HIV Positive ☐ Unknown Status ☐ HIV Negative

Permission to contact you regarding HIV Testing and Support Services? ☐ Yes ☐ No ***(If No, skip to next section)***

When calling, can we identify as HIV Services? ☐ Y ☐ N Does your Emergency Contact know your HIV Status? ☐ Y ☐ N

Would you like to receive monthly HIV Services mailing? ☐ Email ☐ US Post ☐ No, thanks!

Do you have CareAssist? ☐ Yes ☐ No Do you identify as a long-term survivor? ☐ Yes ☐ No ☐ Unsure

Please complete if you are a Youth under the age of 18 and/or have a legal guardian: ☐ N/A

Parent/Guardian Name | Primary Phone: | Alt. Phone:

May we leave a message identifying as Quest? ☐ Yes ☐ No

Street Address | Unit/Apt # | City | State | Zip Code

For Motor Vehicle Accidents Only: ☐ Does Not Apply

Date of Accident | Claim # | Name of Claim's Adjuster | Phone

Attorney's Name (If Applicable) | Attorney's Address | Phone

I certify that the above information is true and accurate:

Client/Patient Signature | Date | Parent/Guardian Signature | Date