Oregon Center for Children and Youth with Special Health Needs

OCCYSHN

Community Connections Network

linking health, education and community services through a network of community-based teams

PATIENT CONTACT INFORMATION

Child's:

First Name: _____ _____Middle I: ____

Last Name: _____

Date of Birth: __ / __ / ____

Gender: ❑ M ❑ F

Parent/Guardian:

Name: _____

Phone: (____) ____ - _____

Address: _____City: _____

Zip: _____ County _____

E-mail: _____

1) **Race: (Optional) Please check only one:**

❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Asian

❑ Native Hawaiian or Pacific Islander ❑ Two or more races ❑ Unknown

2) **Ethnicity: (Optional) Please check only one**

❑ Hispanic ❑ Non-Hispanic ❑ Unknown

3) **Family's Preferred Language:** Spoken: _____ Written: _____

4) **Do you need an interpreter?** ❑ Yes ❑ No

5) **Does your child have a Primary Care Provider?** ❑ Yes ❑ No **If yes, indicate name:** _____

(a regular family doctor, nurse practitioner or clinic)

6) **Does your child receive SSI (Social Security Income)?** ❑ Yes ❑ No

7) **Does your child have health insurance?:** ❑ Yes ❑ No

If yes, indicate Primary Insurance Type: ❑ OHP Standard ❑ OHP Plus ❑ CAWEM ❑ Indian Health Services

❑ Private *(*please specify) _____

8) **Who referred your child to Community Connections Network?** _____

In Partnership with:

OHSU OREGON HEALTH & SCIENCE UNIVERSITY