Specialist Care for Every Child

Child and Adolescent Clinic
971 – 11th Avenue
Longview, WA 98632
360-577-1771

CHILD AND ADOLESCENT CLINIC
REGISTRATION FORM FOR PATIENTS 18+

Pt. #:_____

Legal Name:		**Birthdate:**		**Today's Date:**	
Preferred Name: (If different)		**Preferred Pronouns:**			
Languages Spoken Fluently:		**Sex:** (Circle One)	Male Female Intersex/Other		

Please complete this next section with your information:			
Your Address: City, State, Zip			
Cell Phone:		**Alternate Phone:**	
Email:			
How would you like to receive appointment reminders? (Circle One)	Email Text to Cell Phone Call		

Upon receipt of this form, we will send you information about your portal log-in.

Please check the box in each category that best describes you:

Ethnicity:		**Race: (Choose all that apply)**		**Gender Identity:**		**Sexual Orientation:**	
Hispanic or Latino		White		Male		Heterosexual / Straight	
Not Hispanic Or Latino		Black or African American		Female		Lesbian Gay Homosexual	
Decline to Answer		American Indian or Alaskan Native		Transgender Male Trans Man Female-to-Male (FTM)		Bisexual Pansexual	
		Asian		Transgender Female Trans Woman Male-to-Female (MTF)		Other, Please Specify	
		Hawaiian or Pacific Islander		Gender Queer / Non-Binary Neither exclusively male nor female Two-Spirit		Unknown	
		Other, Please Specify		Other, Please specify:		Decline to Answer	
		Decline to Answer		Unknown			
				Decline to Answer			

Emergency Contact: Who can we call in the event of an emergency?					
Name:		**Relationship:**		**Phone:**	
What information may we share with your emergency contact?					

For office use only: Sent pin for patient portal ☐ Chart updated by: _____