



## PATIENT INFORMATION

Last name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Gender  F  M

SS# \_\_\_\_\_ Date of birth \_\_\_\_\_ Cell phone \_\_\_\_\_

Primary language \_\_\_\_\_ Driver's license # \_\_\_\_\_ Home phone \_\_\_\_\_

E-mail address \_\_\_\_\_ Work phone \_\_\_\_\_

May we leave information on your cell phone/answering machine to confirm your appointment?  Yes  No

Mailing address ( check if same as street address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital status  Single  Married  Widowed  Divorced

Spouse's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Spouse's phone \_\_\_\_\_

### OHRP INFORMATION *(required by the State)*

Ethnicity  Hispanic/Latino  Non-Hispanic/Latino  Decline  
Race  Asian  Black/African American  American Indian  
 Alaskan Native  Hawaiian/Pacific Islander  White/Caucasian  Declined

### EMPLOYMENT

Full-time  Part-time  Not employed  Full-time student  Part-time student  Retired

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer address \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

If patient is a child, parent's name \_\_\_\_\_ Phone \_\_\_\_\_

### INSURANCE

Primary insurance \_\_\_\_\_ Secondary insurance \_\_\_\_\_

Subscriber name \_\_\_\_\_ Subscriber name \_\_\_\_\_

Date of birth \_\_\_\_\_ SS# \_\_\_\_\_ Date of birth \_\_\_\_\_ SS# \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's relationship to patient \_\_\_\_\_ Subscriber's relationship to patient \_\_\_\_\_

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Rogue River Family Practice Clinic to provide my insurance companies with all information necessary to process insurance claims and assign payments to Rogue River Family Practice Clinic all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original.

***I have read and understood all of the above.***

Signature \_\_\_\_\_ Date \_\_\_\_\_