ROGUE RIVER
FAMILY PRACTICE CLINIC

509 E. Main Street
Rogue River, Oregon 97537
www.rogueriverfpc.com
541-582-0505

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 a detailed message on your cell phone/answering machine? ☐ 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 _____