APPLEGATE VALLEY FAMILY MEDICINE

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Cell phone no.: ( )	Email Address**:	Driver's License no.:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Preferred Pharmacy:

Other family members seen here:

Please be advised that we do not have secure email and cannot answer medical questions this way

(The follow questions are voluntary and used solely for Meaningful Use purposes).

Race:	❑ Declined	❑ American Indian/ Alaska Native	❑ Asian	❑ Black/ African American	
		❑ Nat Hawaiian/ Pacific Islander	❑ Other	❑ White	
Religion:	❑ Declined	❑ Buddhist	❑ Catholic	❑ Hindu	❑ Islam
		❑ Jewish	❑ N/A	❑ Other	❑ Protestant
Ethnicity:	❑ Declined	❑ Hispanic or Latino	❑ Not Hispanic or Latino		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is your condition related to on the job accident? (Current or previous) ❑ Yes ❑ No

Is your condition related to a motor vehicle accident? ❑ Yes ❑ No

Is your condition related to any other accident? ❑ Yes ❑ No

Do you have medical insurance? ❑ Yes ❑ No

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ AllCare	❑ Regence BC/BS	❑ HealthNet	❑ Pacific Source
❑ Aetna	❑ United Healthcare	❑ CareSource	❑ Welfare *(Please provide coupon)*	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Street Address:	City:	State:	Zip:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Applegate Valley Family Medicine, MidRogue IPA (billing department) or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*