

- McClaine Street Clinic
- Mount Angel Family Medicine
- Silverton Hospital Immediate Care
- Silverton & Tukwila Specialists Clinic

- Wellspring Integrative Medicine
- Woodburn Family Medicine
- Woodburn Internal Medicine

REGISTRATION & PATIENT INFORMATION

Date: _____ Primary Care Physician: _____ Phone: _____

Patient Information *(Please print clearly)*

Legal Name: _____ Male Female
Last *First* *MI*

Mailing Address: _____
Street / Apartment *City* *State* *Zip*

Physical Address: _____
Street / Apartment *City* *State* *Zip*

Phones: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Birthdate: _____ / _____ / _____ Age: _____ Married: Yes No Student: Yes No

SSN: _____ - _____ - _____ Driver's License #: _____

Employer's Name: _____ Occupation: _____

Employer's Address: _____
Street / Box *City* *State* *Zip*

How do you intend to pay for your services? Cash Credit Card Check Insurance

Provide the following information. As a courtesy to you we will bill your insurance.

If patient is a minor: Mother's Name: _____
Last *First* *MI*

Father's Name: _____
Last *First* *MI*

Who does child live with: Mother Father Mother/Father Other _____

Primary Insurance Company Name: _____ Phone: (_____) _____

Claims Address: _____
Street / Box *City* *State* *Zip*

ID #: _____ Group Number: _____ Effective Date: _____

Check here if information requested below is same as above (if the patient is a minor complete information below about person responsible for health care payments.)

Policy Holder Name: _____

Relationship: _____ Date of Birth: _____

SSN: _____ - _____ - _____ Driver's License #: _____ Phone: (_____) _____

Policy Holder's Home Address: _____
Street / Apartment *City* *State* *Zip*

Policy Holder's Current Employer: _____ Phone: (_____) _____

Secondary Insurance Company Name: _____ Phone: (_____) _____

Claims Address: _____
Street / Box *City* *State* *Zip*

ID #: _____ Group Number: _____ Effective Date: _____

Policy Holder Name: _____

Relationship: _____ Date of Birth: _____

SSN: _____ - _____ - _____ Driver's License #: _____ Phone: (_____) _____

Policy Holder's Home Address: _____
Street / Apartment *City* *State* *Zip*

Policy Holder's Current Employer: _____ Phone: (_____) _____

Emergency Contact Outside of Household: _____ Phone: (_____) _____

Relationship: _____ Alt. Phone: (_____) _____

Do you have an Advanced Directive / Living Will: Yes No

Please complete other side for MVA or Work Injury

NOTE: If you are being seen for a Work Injury or Motor Vehicle Accident please complete the proper section below, if neither applies please skip this section. Thank you.

Work Injury Information

Employer's Workers Compensation Carrier: _____

Address for Claims: _____
Street / Box _____
City _____
State _____
Zip _____

Claim #: _____
Date of Injury: _____

Claim Adjuster's Name: _____
Phone: (____) _____

Is claim currently in an open status: Yes No

Employer at time of injury: _____
Phone: (____) _____

Have you –
Filed a written report with your employer (FORM 801) Yes No
Filed a report with any other Doctor or Hospital (FORM 827) Yes No

Attorney's Name: _____
Phone: (____) _____

Motor Vehicle Accident Information

Patient was: Passenger Driver Pedestrian

Auto Insurance Company for the Patient: _____

Address for Claims: _____
Street / Box _____
City _____
State _____
Zip _____

Claim Number: _____
Date of Accident: _____

Auto Insurance Company for the Driver: _____

Address for Claims: _____
Street / Box _____
City _____
State _____
Zip _____

Claim Number: _____
Date of Accident: _____

Did accident occur in Oregon: Yes No If no, what state: _____

Claim Adjustor's Name: _____
Phone: (____) _____

Insurance Agent's Name: _____
Phone: (____) _____

Policy #: _____
Policy Holder's Name: _____

Policy Holder's Phone Number (____) _____
Relationship to Patient: _____

Attorney's Name: _____
Phone: (____) _____