

- 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

Patient Signature: _____ Date: _____