CENTRAL OREGON FAMILY MEDICINE
Patient Registration Form

Last Name First Name Initial		Social Security #	Primary Phone
Mailing Address City State Zip		Email address:	Secondary Phone
Birth Date Age Sex ☐ M ☐ F	Ethnicity: Race: Language Preference:	☐ Single ☐ Married Spouse Name_____ ☐ Divorced ☐ Widowed	
Employer Name	Occupation	Work Number	
Emergency contact Name	Relationship	Contact Numbers	
Preferred Pharmacy			

Responsible Party (If Different from Patient Information)

Last Name First Name Initial	Birth Date	Social Security #	
Mailing Address City State Zip	Home Phone	Cell Phone	

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Name Policy # Group#	Name Policy# Group#

MISCELLANEOUS INFORMATION

Do we have your permission to:

Leave a message on your answering machine at home ☐ Yes ☐ No
Leave a message at your place of employment? ☐ Yes ☐ No
Leave a message with a household member? ☐ Yes ☐ No **If yes, with whom**: _____
Keep a photo of you in your electronic medical chart? ☐ Yes ☐ No **Relationship:** _____
Process your prescription when applicable via electronic (eRX) which may be handled outside our office? ☐Yes ☐ No

I understand that health information disclosed pursuant to the above authorization may be re-disclosed and no longer protected under HIPAA if the recipient is not subject to federal privacy regulations.

If you wish to authorize release of all health information to another individual, please sign a separate authorization for disclosure.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage as listed above and assign directly to Central Oregon Family Medicine all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance claims submissions. I acknowledge by my signature that I have read and understand the Financial Agreement of Central Oregon Family Medicine.

X_____ _____

Signature of Patient or Responsible Party **Date**

PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID TO YOUR APPOINTMENT.