PATIENT INFORMATION

Name:_____ **Marital Status:** _____
First MI Last

Address: _____
Street City/State Zip

Home #: _____ **Mobile #:** _____ **Work #:** _____

Email Address: _____ **Preferred Method of Notification for Reminders:** ☐Email ☐Text ☐Voice

Birth Date: _____ **Age:** ____ **Sex:** ____ **Soc Sec #:** _____ **Race/Ethnicity:** _____

Employer: _____**Address:** _____
Street City/State Zip

FINANCIALLY RESPONSIBLE PARTY

Name:_____**Marital Status:** _____
First MI Last

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

Home #: _____ **Mobile #:** _____ **Work #:** _____

Birth Date: _____ **Sex:** _____ **Soc Sec #:** _____**Relationship to Patient** _____

IMMEDIATE FAMILY MEMBERS	RELATION	DOB

Have any of the above Family Members been seen in Family Medical Group Silverton or Molalla in the past? ____Yes ____No
If Yes, Who? _____

INSURANCE

Primary Ins Name: _____ **Policy ID#:** _____ **Group:** _____

Subscriber Name: _____ **DOB:** _____ **Relation to Patient:** _____

Secondary Ins Name: _____ **Policy ID#:** _____ **Group:** _____

Subscriber Name: _____ **DOB:** _____ **Relation to Patient:**_____

IN CASE OF EMERGENCY

Name: _____ **Phone:** _____

How related? _____

AUTHORIZATION TO RELEASE INFORMATION * ASSIGNMENT OF INSURANCE BENEFIT

I hereby authorized Family Medical Group of Silverton/Molalla to release to the insurance company named above any information (may included information protected by federal law i.e. drug, alcohol abuse or mental health information) acquired in the course of the examination of treatment. I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Family Medical Group of Silverton/Molalla any and all insurance benefits due to me to the full extent of my financial obligation to said provider. I understand my insurance coverage is a relationship between my insurance company and myself and I agree to accept financial responsibility for payment for charges incurred. In the event of non-payment, I will bear the cost and/or court costs and reasonable legal fees should this be required.

PRIVACY PRACTICES NOTIFICATION

I have had the opportunity to read the Notice of Privacy Practices. I understand that if I have any questions or concerns, or if I wish to receive additional copies of the notice at any time, I may do so by calling this office.

Signed: _____ **Date:** _____
(If patient is minor, parent or guardian sign)