Southern Oregon Rheumatology Clinic, SORC

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Registration and Patient Information

(The following information is very important to your health. Please take the time to fully and accurately fill out this form)

Patient Name____ Gender: ☐ Male ☐ Female ☐ Non-Gender
Last, First, Middle

Social Sec #____ Marital Status: S D M W O Date of Birth: _______________

Mailing Address____ City_____________________ State_________ Zip___________

Home Phone: ( )______________ Cell ( )______________ Street Address (if different) ______________________________

Please select one or more of the following races:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Latino or Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ________________ ☐ Decline

Preferred Language: English or Spanish Alternate Communication Preference to Phone: Mail or Email

Email Address: ____

Message Authorization: "If you have an answering machine **or voicemail,** may we leave a message? Yes No

Employer____ Occupation_________________________________

Work Address____ Work Phone ( ) _________________

Who referred you to our office?___________________________________ Family Dr/NP ____________________________

Name of spouse/parent/ or guardian______________________________ Address_____________________________________

Employer____ Work Phone ( ) _________________

****Emergency contact (not living with you)*****___________________________________ Phone ( )______________________

PRIMARY INSURANCE

(Patient's own insurance policy or spouse's if "not" employed)

Name of Insurance______________________________________ ID#_______________________ Group # ________________

Subscribers Name_______________________________________ Subscriber's Social Security # _________________________

Relationship to Patient___________________________________ Subscriber's Birth Date ______________________________

Address (if different from patient)____ Phone ( )_________________________

Subscribers Employer____ Work Phone ( )_________________

SECONDARY INSURANCE

*(Are you covered by additional insurance? **If yes**, complete this section)*

Name of Insurance______________________________________ ID#_______________________ Group # ________________

Subscribers Name_______________________________________ Subscriber's Social Security # _________________________

Relationship to Patient___________________________________ Subscriber's Birth Date ______________________________

Address (if different from patient)____ Phone ( ) _________________________

Subscribers Employer____ Work Phone ( )_________________

***Is this visit related to a work injury?** No Yes If yes, see / call receptionist

***Is this related to a car accident?** No Yes If yes, see / call receptionist

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits directly to my healthcare provider who accepts assignment.

I understand that I am financially responsible for all charges whether or not paid by insurance.

_______________________________________ _______________________________ __________________

Responsible Party Signature **Relationship to patient** **Date**

Revised 06/17

I attest that the above information is true and correct to the best of my knowledge