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**

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