BEAR CREEK
MEDICAL PLAZA

1801 Hwy 99 North, Suite 2
Ashland, OR 97520
Phone (541) 488-4464
Fax (541) 488-3772

PATIENT INFORMATION (Please Print)

_____ _____ _____ Date of Birth: _____ / _____ / _____
First Name Middle Last

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Domestic Partner SS #: _____

_____ _____ _____
Mailing Address City and State Zip Code

_____ _____ _____
Home Phone Cell Phone Email Address

Employer: _____ Work Phone: _____
Company Name

OK to leave messages at ☐ Home ☐ Cell ☐ Email ☐ No Messages Statements sent via Email ☐ yes ☐ no

Spouse's Name (parent's name if patient is a minor) _____ Preferred Pharmacy_____

EMERGENCY CONTACT INFORMATION

_____ _____ _____ _____
Contact Name Relationship Home Phone Alternate Phone

May we share information with your emergency contact? ☐ YES ☐ NO

INSURANCE INFORMATION

☐ **I do not have any insurance** **Is your visit today due to a work related injury or vehicle accident? ☐ Yes ☐ No Date of injury_____**

Primary Insurance: _____
Subscriber's Name (as listed on card)

_____ _____ _____ _____
Insurance Company Name Subscriber's ID # Group Subscriber's DOB

Secondary Insurance: _____
Subscriber's Name (as listed on card)

_____ _____ _____ _____
Insurance Company Name Subscriber's ID # Group # Subscriber's DOB

Insurance Authorization and Assignment: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

Acknowledgement of Receipt of Privacy Notice: You have the right to receive a written description of our Notice of Privacy Policy detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice:

Patient or Guardian Signature: _____ **Date:** _____