BEAR CREEK
MEDICAL PLAZA

1801 Hwy 99 North
Suite 2
Ashland OR 97520
PH 541.488.4464
FAX 541.488.3772

New Patient Information

Please Complete In Full

Patient's Name (Please Print) | S.S. # | ☐S ☐M ☐W ☐D ☐SEP Marital Status: | ☐Male ☐Female Sex: | ___ / ___ / ___ Birth Date: | Age:

Street Address ☐Permanent ☐Temporary | City and State | Zip Code | Home Phone #

Patient's or Parent's Employer | Occupation (Indicate if student) | How Long Employed | Bus. Phone # | Ext.

Employer's Street Address | City and State | Zip Code

Drug Allergies, if any

Spouse or Parent's Name | S.S.# | Birth Date

Spouse or Parent's Employer | Occupation (Indicate if student) | How Long Employed | Bus. Phone # | Ext.

Employer's Street Address | City and State | Zip Code

Spouse's Street Address (If divorced or separated) | City and State | Zip Code | Home Phone #

Please Read: If you don't have insurance, all charges are due at the time of services. If you are insured, your insurance company will be billed - you're responsible for the balance.

Person responsible for payment (If not above) | Street Address, City and State | Zip Code | Home Phone #

☐ Blue Shield (Give name of policy holder) | Effective Date | Certificate | Group # | Coverage Code

☐ Other (Write in name of insurance company) | Effective Date | Policy #

☐ Medicare # | Railroad Retirement #

☐ Medicaid | Effective Date | Program # | County # | Case # | Account #

☐ Industrial | ☐ Yes ☐ No Were you injured on the job? | _____ / ____ / _____ Date of Injury | Industrial Claim #

☐ Accident | ☐ Yes ☐ No Was an automobile involved? | _____ / ____ / _____ Date of Accident | Name of Attorney

☐ Yes ☐ No Were x-rays taken of this injury or problem? | If yes, where were x-rays take (hospital, etc) | ____/____/_____ Date x-rays taken

Has any member of your immediate family been treated by our physician(s) before? Include name of physician and family member.

Referred by | Street Address, City and State | Zip Code | Home Phone #

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. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

Insurance Authorization and Assignment

Name of Policy Holder _____ **HIC Number** _____

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to _____ for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I Authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.)

Acknowledgment of Receipt of Privacy Notice - I have been presented with a copy of this provider's **Notice of Privacy Policies**, 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; _____

Signature _____ **Date** _____