Valley Family Practice 3524 Heathrow Way, Medford OR 97504 | P: (541) 646-3505 F: (541) 646-3553
a Rogue Valley Physicians Clinic

PLEASE FILL IN THE FOLLOWING INFORMATION COMPLETELY *(Please Print)*

Legal Name: _____ Home Phone: _____ Date: _____
last first middle

PRIMARY CARE PHYSICIAN: _____ Cell Phone: _____

Other family members' names and dates of birth: _____

_____

Mailing Address: _____
Street, P.O. Box City State Zip

Date of Birth _____ Social Security # _____ Sex _____ Marital Status _____

Race _____ Language _____ Hispanic or Latino [ ] Yes [ ] No

Employer _____ Address _____ Work Phone _____

Email Address _____

Have you ever received medical treatment under another name? _____
(If yes, under what name?)

Emergency Contact: Name _____ **Relation** _____ **Phone** _____

How did you hear about us? (Please choose one) Friend _____ **/ Radio / Phonebook / Other** _____

Guarantor (Responsible Party if different from patient) or Custodial Parent

Name: _____ Home Phone: _____
last first middle

Address (if different) _____
Street, P.O. Box City State Zip

Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____ Occupation _____

Spouse/Parent/Relative/Close Friend (please circle one) (Different person from above please)

Name: _____ Home Phone: _____
last first middle

Address (if different) _____
Street, P.O. Box City State Zip

Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____ Occupation _____

INSURANCE INFORMATION *(Please check those which apply)*

I Have: Medicare _____ Medicaid _____ Health Insurance _____ No Insurance _____

PRIMARY HEALTH INSURANCE **PLEASE PRESENT CARD AT CHECK IN**

Company: _____ Policy# _____ Group# _____

Insured Name: _____ DOB _____ SS# _____ Sex _____

Employer _____ Relationship to Patient _____

SECOND HEALTH INSURANCE

Company: _____ Policy# _____ Group# _____

Insured Name: _____ DOB _____ SS# _____ Sex _____

Employer _____ Relationship to Patient _____

I am receiving medical treatment as a result of an accident: Yes _____ No _____ **(Please complete accident form)**

If Yes, what type of accident? Motor Vehicle _____ Work Accident _____ Other _____

AUTHORIZATION TO PAY-RELEASE MEDICAL INFORMATION

I hereby authorize Valley Family Practice LLC the release of any information as may be required by an attorney, insurance company or referring Physicians for the purpose of medical treatment or follow up. I hereby assign all payments directly to Rogue Valley Physicians, P.C. to which I am entitled for expenses related to services performed. I understand I am financially responsible for all charges. Should it become necessary to collect monies in court; all court costs and attorney fees are my responsibility.

Patient's Signature: _____ **Date** _____

We request that copays, deductibles, and non covered services be paid at the time services are rendered.