PLEASE FILL OUT BOTH PAGES

PATRICIA O'HARE
1200 Queen Ave SE Albany, OR 97322
Phone (541)936-3025
Fax (541) 936-3026

Patient Information

Date of Birth:______________ Age:_______ Gender: M___ F___ Other______

Name:____________________________________What would you liked to be called?_____________________

Address:_______________________________________City, State, Zip:________________________________

Preferred Phone:__________________ [ ] home [ ] cell [ ] work Email:_____________________________

Alternate Phone:___________________ [ ] home [ ] cell [ ] work Preferred Language: _________________

Ethnicity: [ ] Hispanic or Latino [ ] non-Hispanic or Latino [ ] other Race:________________________

Height: ____________________Weight: __________ Primary Care Provider: ______________________________

Preferred pharmacy: ______________________________ Pharmacy Address, City _____________________________

Occupation: ____________________________________

Emergency Contact

Name: ______________________________ Relationship: _________________________

Phone: ______________________________

Responsible Party [ ] same as patient

Name: ______________________________ Employer: ______________________________

Address: ____________________________ Phone: ________________________________

City, State, Zip: _______________________ Date of Birth: ___________________________

Insurance

Copy of card is required and information below must be filled out for office to bill insurance.

Primary Insurance:_________________________Subscriber's Name: ______________________DOB: _______

Relationship to Patient: ____________________________

Secondary Insurance:_____________________________Subscriber's Name: ____________________DOB: _____

Relationship to Patient: ____________________________

Insurance Authorization and Assignment

I acknowledge that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the practice, and authorize her to release information necessary to secure payment. I understand I am responsible for any amount not paid for by my insurance.

Signature: ____ Date: _________________

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Please complete the following form regarding release of medical information. It is our office policy to comply with state law keeping medical diagnosis and treatment information confidential unless otherwise authorized by the patient. Medical information will only be disclosed to those listed on this form.

Patient Name: ___________________________________ Date of Birth: _____________________________

Do we have permission to:

Leave a message on your voicemail / answering machine?

Yes______ No______

May we contact you at work?

Yes______ No______

May we discuss your medical condition and / or history with other members in your household?

Yes______ No______

If yes, whom: ____

Relationship: ___________________________ Phone: ____________________________________

Please Note:

* **This Authorization is limited to VERBAL discussions/or messages. No paper copies or electronic access to health records will be provide to persons above without written Authorization.**
* **A copy of the Office Privacy Policy will be provided upon request.**
* **Electronic Records will be provide to your Primary Care Provider and/or other Medical Professionals unless otherwise specified.**
* **This Authorization will remain in effect until revoked. You may revoke this authorization at anytime by contacting our office (541) 936-3025 or you may specify a date below.**

____

Signature: ____ **Date:** ______________