APPLEGATE MEDICAL ASSOCIATES

689 E 19th Ave
Eugene, OR 97401

PHONE 541-868-1876
FAX 541-868-0932

PATIENT REGISTRATION

Patient Name _____ Birthdate_____

Sex M F Marital Status M W D S

Street Address _____ Mailing Address _____

City _____ State _____ Zip Code _____

Telephone (Home) _____ (Work/Other) _____

Social Security Number _____ Employer_____

Primary Physician _____ Who referred you?_____

Person to contact in emergency _____ EmergencyTelephone_____

Preferred Pharmacy _____ Special Needs _____

Responsible Party (Person responsible for payment) Self Spouse Parent Other

Name of Responsible Party if other than Self) _____

Address: _____

City _____ State: _____ Zip Code: _____

Primary Medical Insurance: _____ Insured party: Self Spouse Parent Other

ID# _____ SocSec# _____ Group/Plan # _____

Name of Insured (if other than Self) _____

Ins. Address: _____ City _____ State _____ Zip Code _____

Secondary Medical Insurance: _____

Insured party: Self Spouse Parent Other ID# / SocSec# _____ Group/Plan# _____

Name of Insured (if other than Self): _____

Ins. Address _____ City _____ State _____Zip Code _____

PERMISSION TO RELEASE INFORMATION & ASSIGNMENT

I hereby authorize Applegate Medical Associates to furnish to the insurance company or other payer, or their representatives, or either myself or the subscriber, or to the referring physician all medical or financial information which may be requested concerning the patient's present illness, injury or condition.. 1 hereby authorize my insurance benefits be paid directly to Applegate Medical Associates, and I understand that I am financially responsible for non-covered services. I understand that it is my responsibility to determine if my physician is a member of my insurance plan.

_____ _____ _____

Patient Signature Parent/Guardian Signature Date

_____ _____ _____

Patient Signature Parent/Guardian Signature Date

Please initial rec'd Privacy Policy _____ OR Refused Privacy Policy _____