Siskiyou Family Health
1025 Siskiyou Blvd.
Ashland, Oregon 97520

Date:__________________
Name:____ Birthdate: _______________
Address:____
City, State, Zip:_______________________________ Soc Sec#:________________
Home Phone:____________________ Work Phone:__________________________
Cell Phone:___________________ Occupation:____________________________
Male_______ Female_______ Employer:__________________________
Single____ Married____ Divorced____ Widowed_____ Separated____ Partner____
Referred By:____________________
Emergency Contact not living with you:_________________ Phone:_____________
Spouse or closest
relative:________________________Phone:____________________

If you are not the policy holder on your insurance, then please fill out the following:
INSURED PARTY CIRCLE ONE: SELF SPOUSE PARENT OTHER

Name of holder:___________________ Date of birth:______________
Phone number:__________________ Soc Sec #___________________
Address:____

Responsible Party
Name:____________________ Relationship to patient:________________________
Birthdate:__________________ Soc Sec #:________________________________
Address:__________________________ Phone:_____________________________

I give Siskiyou Family Health office permission to give test results and other health related information to (ex: family members/other physicians)_________________________.

Please let us know if we can leave information on your message machine.
You May_________ May not___________

Authorization and Release
I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that no insurance covers medical expenses 100% all the time. In the event that my insurance does not pay for the services (such as preventive care, immunizations, etc.) rendered by Siskiyou Family Health (or agents), I accept responsibility and agree to pay in full the amount owed. I understand that if I have no insurance coverage at the time of services that I will be responsible for all charges incurred and agree to pay in full. I understand I will be responsible for the fee charged for any missed appointments.

X____________________________________ ______________________
signature date

I have received a copy of the Notice of Privacy Practices.______________________________
Initial

I have received a copy of Siskiyou Family Health office policy:______________________