FALL CREEK
INTERNAL MEDICINE

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

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PATIENT INFORMATION/REGISTRATION

PATIENT NAME	DOB	GENDER	MARITAL STATUS

SOCIAL SECURITY #		DRIVERS LICENCE #	

ADDRESS	CITY	STATE	ZIP CODE

PRIMARY PHONE	OK to Leave A Message	Appointment Confirmation Calls
	□ BRIEF □ DETAILED	□ YES □ NO

SECONDARY PHONE	OK to Leave A Message	Appointment Confirmation Calls
	□ BRIEF □ DETAILED	□ YES □ NO

EMAIL Address	

ETHINICITY / RACE		LANGUAGE	
□ African American □ Alaska Native □ American Indian □ Asian □ European	□ Middle Eastern □ Hispanic □ White □ Other _____ □ Unreported/Refused to Report	□ English □ Spanish □ Russian	□ Indian □ Other _____ **TRANSLATOR** □ YES □ NO

Employment Status	□ Full-time	□ Part-time	□ Self-employed	□ Retired	□ Unemployed

EMPLOYER	OCCUPATION

Work Phone		May we contact you at work?	□ YES □ NO

EMERGENCY CONTACTS			
NAME		PHONE NUMBER	
NAME		PHONE NUMBER	

INSURANCE INFORMATION (Complete ALL Sections)			
PRIMARY INSURANCE			
INSURANCE NAME			
PATIENT ID NUMBER		GROUP NUMBER	
SECONDARY INSURANCE			
INSURANCE NAME			
PATIENT ID NUMBER		GROUP NUMBER	

By signing below, I acknowledge that the information I provided is correct to the best of my ability. I hereby authorize FCIM to release to my Health Insurance carrier any information acquired in the course of my examination or treatment including medical records, test results, and billing information.

NAME:_____ DATE _____