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	

EMERGENCY CONTACTS

NAME	RELATION	PHONE NUMBER

RACE	ETHNICITY	LANGUAGE	TRANSLATOR
□ American Indian /Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ Black or African American □ White □ Hispanic □ Other Race □ Unreported/ Refused to Report	□ Hispanic or Latino □ Not Hispanic or Latino □ Unreported/Refused to Report	□ English □ Spanish □ Russian □ Indian □ Other _____	□ YES □ NO

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

EMPLOYER	OCCUPATION

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 _____