

# Welcome to Oregon City Family Practice Clinic, P.C.

If you need assistance completing paperwork, please ask us. We are here for you.

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender M F

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Ethnicity \_\_\_\_\_ Race \_\_\_\_\_ Primary Language \_\_\_\_\_

Anyone you authorize to receive Health and Accounting information on your behalf?

(If patient is a minor, please list both parents)

1. \_\_\_\_\_ Relationship: \_\_\_\_\_

2. \_\_\_\_\_ Relationship: \_\_\_\_\_

Are there any court orders regarding guardianship or custody, if child? YES NO

## STUDENT OR EMPLOYER INFORMATION

\_\_\_\_ Full-time Student \_\_\_\_ Part-time Student

Occupation \_\_\_\_\_ Employer/University \_\_\_\_\_

Employer/University Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## PARENT OR SPOUSE INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

SSN# (if insured) \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

(please list person different than above)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us? (Doctor Referral, Friend, Family member, etc.) \_\_\_\_\_