



205 N. Phoenix Rd, Suite 325, Phoenix, OR 97535
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Registration Update (please print clearly)

Patient's update applies to:

Last Name: _____ First: _____ DOB: _____

Last Name: _____ First: _____ DOB: _____

Last Name: _____ First: _____ DOB: _____

Last Name: _____ First: _____ DOB: _____

Last Name: _____ First: _____ DOB: _____

Preferred Pharmacy & Location: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ Primary Phone: Cell/Home/Work _____ Appt Reminders? Yes/No

Emergency Contact: _____ Phone: _____ Relationship: _____

Responsible Party, if Patient is a minor:

Parent/Guardian: _____ DOB: _____ Phone: _____ Same address? Yes/No

Parent/Guardian: _____ DOB: _____ Phone: _____ Same address? Yes/No

Insurance Information:

Primary Insurance _____ Policy# _____ Group# _____

Subscriber _____ DOB _____ SS# _____ Relationship _____

Secondary Insurance _____ Policy# _____ Group# _____

Subscriber _____ DOB _____ SS# _____ Relationship _____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Murphy Creek Wellness to provide my insurance companies with all the information necessary to process insurance claims and assign payments to Murphy Creek Wellness all the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understand all of the above.

Signature: _____ Date: _____