Murphy Creek Wellness

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P 541-690-1525 | F 541-690-1527 | Murphycreekwellness.com

Patient Registration (please print clearly)

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

SS#:_____ Preferred Language: _____

Marital Status: Single/Married/Divorced Preferred Pharmacy & Location: _____

Race: ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ White ☐ African American ☐ Declined to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Gender Identity: ☐ Male ☐ Female ☐ Male to Female ☐ Female to Male ☐ Decline to Answer
☐ Genderqueer(neither male nor female) ☐ Other(please specify):_____

Driver's License #: _____

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: _____

Employer: _____ Phone: _____ Occupation: _____

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: _____