Please use black ink only

Patient First Name	Middle Name	Last Name	Age	Birth Date
Mailing Address		City	State	Zip
Street Address		City	State	Zip

Home Phone	Cell Phone	Employer Name	Employer Phone	Position
Marital Status (Circle One) M S W D P	Patients Social Security #	Doctor to Be Seen	Primary Doctor	Referring Doctor

Preferred Pharmacy ___________________________________

May we leave medical and accounting info on voicemail?

Home Cell Both

May we contact you at work? Yes No

Appointment and health maintenance reminders will be sent out via text and through the patient portal.

Email Address:

Race (Optional) Please Check:

American Indian or Alaska Native ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐

Black or African American ☐ Other☐ Prefer Not To Answer ☐

Ethnicity

Hispanic or Latin ☐ Not Hispanic or Latin ☐ Prefer Not To Answer ☐

Preferred Language

EMERGENCY CONTACTS

Emergency Contact Name #1 (Spouse if married)	Relationship:	Personal Number:	Work Number:
Emergency Contact Name #2	Relationship:	Personal Number:	Work Number:

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company		Name of Subscriber		Relationship to Patient
Subscribers Birth Date	Subscribers Social Sec. #	Subscriber/Member/Client ID #	Group #	
Subscribers mailing address if different than yours:				

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company		Name of Subscriber		Relationship to Patient
Subscribers Birth Date	Subscribers Social Sec. #	Subscriber/Member/Client ID #	Group #	
Subscribers mailing address if different than yours				

IF PATIENT IS UNDER 18 YEARS OLD PLEASE COMPLETE THIS SECTION

Legal Guardian's Full Name	Relation to Patient		Birth Date
Guardian's Social Security #	Guardian's Phone #		
Mailing Address If Different Than Above	City	State	Zip
Guardian's Employer Name	Position/Title		Employer Phone #

If you were not offered the Notice of Privacy Practices at check in please ask for it. It is also available on our website www.ecwg.net

PLEASE FULLY COMPLETE BOTH FRONT AND BACK OF THIS FORM

Revised 01/21/2021

MEDICAL INFORMATION AUTHORIZATION

As required by law, for anyone at our facility to discuss your medical care with your family and friends you must list who we can speak with. By listing someone in the following area we are allowed to give them any information from medical, to billing, to appointment times whether they call us or we are calling you and they answer. It is NOT the same as an emergency contact. This is not an area to list other physicians as we are allowed to speak with them about you for continuity of care.

Name:____ Relation:______________________________

Name:____ Relation:______________________________

Name:____ Relation:______________________________

X____________________________________ **X**____ ______________

Patient's Signature **Guardian's Signature (if patient is under 18)** **Date**

CREDIT POLICY

Our Credit and Collections Policy is a necessary and uncomfortable part of assuring the financial resources needed to maintain quality health services for our patients. Because of this, we request payment at the time of service if you are uninsured. If you are insured please provide us with a copy of your insurance card.

We bill all insurance companies as a courtesy when you provide us with your current information. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. We do not have any control over your insurance companies interpretation of their responsibility to pay your bill or when. Our agreement is with you, the patient. We accept Visa, Master Card, and Discover.

If you have any questions, please do not hesitate to contact our billing office at 541-389-3300.

X____________________________________ **X**____ ______________

Patient's Signature **Guardian's Signature (if patient is under 18)** **Date**

Acknowledgement

I acknowledge that I have received the Notice of Privacy Practices from East Cascade Women's Group.

X____________________________________ **X**____ ______________

Patient's Signature **Guardian's Signature (if patient is under 18)** **Date**

I hereby authorize East Cascade Women's Group to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to said doctors all monies to which they are entitled for medical and/or surgical expense relative to the services performed from time to time, but not to exceed my indebtedness to said physicians and surgeons. I understand I am financially responsible to said doctors for all charges for services received.

X____________________________________ **X**____ ______________

Patient's Signature **Guardian's Signature (if patient is under 18)** **Date**