Ashland Family Healthcare
420 Williamson Way
Ashland, OR 97520
(541) 488-3616 Phone
Dr. Miriam Soriano

PATIENT DEMOGRAPHIC INFORMATION	ACCT #6999			02/04/2013
LEGAL NAME: *			DATE OF BIRTH:	
SOCIAL SECURITY:		MARITAL STATUS:	SEX:	
HOME PHONE:	CELL:		EMAIL:	
ADDRESS:			* ZIP Code:________	
RACE: *	☐ Caucasian ☐ Asian ☐ Black ☐ Pacific Islander ☐ American Indian ☐ Other:____________			
ETHNICITY: *	☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino			
PREFERRED LANGUAGE	☐ English ☐ Spanish ☐ Other ____________			
PREFERRED PHARMACY:				
EMPLOYER:				
OCCUPATION:			WORK PHONE:	
HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? ☐Yes ☐No IF YES, UNDER WHAT NAME? ____________				
EMERGENCY CONTACT: NAME	*		Phone:	
RELATIONSHIP:	*			

*GUARANTOR (**RESPONSIBLE PARTY if different from patient**) OR CUSTODIAL PARENT*					
NAME:		ADDRESS:			
HOME PHONE:		SS#		DATE OF BIRTH:	
EMPLOYER:				OCCUPATION:	
RELATIONSHIP:				WORKPHONE:	
Spouse/Partner *	Name:				
	Phone:				

INSURANCE INFORMATION					
I HAVE: ☐MEDICARE ☐MEDICAID CARD ☐HEALTH INSURANCE ☐NO INSURANCE					
MEDICARE ID# ____________		OREGON HEALTH PLAN ID# ____________			
Primary Insurance Information					
NAME:		ADDRESS:			
ID/POLICY #:		GROUP #:			
INSURED NAME:		DOB: *		SEX:	
RELATIONSHIP TO PT:	*	EMPLOYER:			
Secondary Insurance Information					
NAME:		ADDRESS:			
ID/POLICY #:		GROUP #:			
INSURED NAME:		DOB:		SEX:	
RELATIONSHIP TO PT:		EMPLOYER:			

CONSENT FOR TREATMENT AND RELEASE

I authorize Dr. Soriano and her staff to examine me (or my dependent) and recommend treatment. I understand that no guarantees are made and that I am ultimately responsible for my well-being and for following through on suggested treatments/tests.
I allow Ashland Family Health Care to release all medical records to referring Health Care Providers. I allow fax transmittal of my medical records if needed.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents under 18, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize my insurance company to pay and hereby assign Ashland Family Healthcare all benefits, if any, otherwise payable to me for my physician's services.

Signature: ______________________________ Date: ____________________