



## Patient Registration *(please print clearly)*

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Birth Sex: ☐ Male ☐ Female  
SSN: \_\_\_\_\_ Driver License #: \_\_\_\_\_  
Preferred Language: \_\_\_\_\_ Would you like a medical interpreter scheduled for all visits? ☐ Yes ☐ No  
I identify as: ☐ Female ☐ Female-to-Male Transgender ☐ Non-Conforming  
☐ Male ☐ Male-to-Female Transgender  
☐ Other: \_\_\_\_\_ ☐ Decline to answer  
Race: ☐ Asian ☐ American Indian or Alaska Native ☐ African American  
☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Decline to answer  
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer  
Marital Status: ☐ Single ☐ Married ☐ Divorced  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ ☐ Home ☐ Work ☐ Cell Email: \_\_\_\_\_  
Secondary Phone: \_\_\_\_\_ ☐ Home ☐ Work ☐ Cell  
Preferred Pharmacy: \_\_\_\_\_ Appointment Reminders OK? ☐ Yes ☐ No  
Ok to leave message on: Home? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

I authorize treatment of the person named above and accept financial responsibility for all treatment provided.  
I authorize Mountainview to provide my insurance companies with all information necessary to process insurance claims and assign payments to Mountainview all of 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 understood all of the above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Jon E. L. Ermshar, MD | Brett Rasmussen, PA-C**

1716 Williams Hwy., Grants Pass, OR 97527 | Phone (541) 474-6053 | Fax (541) 474-4527