



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