



Junction City/Harrisburg Clinic Patient Registration Form

355 W. 3rd Ave

Junction City, OR 97448

Ph: 541-998-6750 Fax: 541-998-1247

PLEASE PRINT & COMPLETE ALL SECTIONS

Patient's Legal Name (Last-First-MI)		Sex	Date of Birth	Home Phone
				()
Mailing Address	City	State	Zip Code	Cell Phone
				()
Physical Address (if different than above)	City	State	Zip Code	Soc Security Number
Patient Employer	Employer			Employer Phone
				()
Spouse Name	Cell Phone	Employer Phone	Employer	
	()	()		
Primary Insurance	Subscriber	Date of Birth	Subscriber Soc Sec Number	
Secondary Insurance	Subscriber	Date of Birth	Subscriber Soc Sec Number	

EMERGENCY CONTACT(S)	Phone(s)	Relationship
_____	_____	_____
_____	_____	_____

RELEASE OF INFORMATION: I give permission to the following person(s) to have access to my medical records & information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Date: _____

Signature to authorize the above release of information. If fifteen and older, must sign for themselves.

Insurance Authorization and Assignment

I understand that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay all costs and expenses including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of medical benefits from my insurance company and/or Medicare directly to my physician. I understand some services provided might incur costs from outside laboratories and/or radiology providers.

Consent for treatment. I wish to receive examination and treatment for my medical condition. I understand that my practitioner will inform me of recommendations related to my treatment and that, unless I object, this consent includes any tests or examinations.

Signature: _____ Date: _____

