Groskopp & Ryland
HELPING YOU ACHIEVE YOUR OPTIMAL HEALTH

800 E. Main St., Medford OR 97504 | P: (541) 608-7683 F: (541) 608-7689
a Rogue Valley Physicians Clinic

PLEASE FILL IN THE FOLLOWING INFORMATION COMPLETELY *(PLEASE USE BLACK INK ONLY)*

Legal Name: _____ Home Phone: _____ Date: _____
last first middle

PRIMARY CARE PHYSICIAN: _____ Cell Phone:_____

Other family members' names and dates of birth:_____

_____

Mailing Address: _____
Street, P.O. Box City State Zip

Date of Birth _____ Social Security # _____ Sex _____ Marital Status _____

Race_____ Language_____ Hispanic or Latino [ ] Yes [ ] No

Employer _____ Address _____ Work Phone_____

Email Address _____

Have you ever received medical treatment under another name? _____
(If yes, under what name?)

Emergency Contact: Name _____ Relation _____Phone _____

How did you hear about us? (Please choose one) Friend_____ / Radio / Phonebook / Other_____

Guarantor (Responsible Party if different from patient) or Custodial Parent

Name: _____ Home Phone: _____
last first middle

Address (if different) _____
Street, P.O. Box City State Zip

Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____ Occupation _____

Spouse/Parent/Relative/Close Friend (please circle one) (Different person from above please)

Name: _____ Home Phone: _____
last first middle

Address (if different) _____
Street, P.O. Box City State Zip

Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____ Occupation _____

INSURANCE INFORMATION ***(Please check those which apply)***

I Have: Medicare _____ Medicaid _____ Health Insurance _____ No Insurance _____

PRIMARY HEALTH INSURANCE **PLEASE PRESENT CARD AT CHECK IN**

Company: _____ Policy# _____ Group# _____

Insured Name: _____ DOB _____ SS# _____Sex _____

Employer _____ Relationship to Patient _____

SECOND HEALTH INSURANCE

Company: _____ Policy# _____ Group# _____

Insured Name: _____ DOB _____ SS# _____Sex _____

Employer _____ Relationship to Patient _____

I am receiving medical treatment as a result of an accident: Yes _____ No _____ **(Please complete accident form)**
If Yes, what type of accident? Motor Vehicle _____ Work Accident _____ Other _____

AUTHORIZATION TO PAY-RELEASE MEDICAL INFORMATION

I hereby authorize Groskopp & Ryland LLC the release of any information as may be required by an attorney, insurance company or referring Physicians for the purpose of medical treatment or follow up. I hereby assign all payments directly to Rogue Valley Physicians, P.C. to which I am entitled for expenses related to services performed. I understand I am financially responsible for all charges. Should it become necessary to collect monies in court; all court costs and attorney fees are my responsibility.

Patient's Signature:_____ Date_____

We request that copays, deductibles, and non covered services be paid at the time services are rendered.