Heather A. Kahn MD, PC
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702 SW Ramsey Ave, Ste 120
Grants Pass, Oregon 97527
541-244-2197

PATIENT REGISTRATION

PATIENT INFORMATION

Last name________ First________ Middle________ Date of birth________

Street address________

Mailing address (☐ check if same as street address)________

City________ State________ Zip________

Phone________ May we leave information at this number to confirm your appointment? ☐ Yes ☐ No

Sex ☐ F ☐ M Marital status ☐ Single ☐ Married ☐ Other SS#________

Employment status ☐ Employed ☐ Not employed ☐ Full-time student ☐ Part-time student ☐ Retired

Employer________ Phone________

Employer address________

Whom may we thank for referring you?________

With whom may we share your healthcare information?

Name________ Relation________

Emergency contact________ Phone________

Current pharmacy________ Phone________

Previous healthcare provider________ Phone________

INSURANCE INFORMATION

Primary insurance________ Group ID________ Member ID________

Secondary insurance________ Group ID________ Member ID________

Note: AllCare Health is the only Oregon Health Plan (OHP) our office accepts. AllCare Health ID________

☐ Check if patient is responsible. If responsible party is someone other than patient, complete info below.

Last name________ First________ Middle________ Phone________

This person is: ☐ my parent ☐ my spouse ☐ someone else Relationship________

Address (☐ check if same as patient address)________

City________ State________ Zip________

SS#________ Date of birth________ Employer________

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Rogue Medicine to provide my insurance companies with all information necessary to process insurance claims and assign payments to Rogue Medicine 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. If it becomes necessary to effect collections for any amount owed, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

Patient or guarantor signature________ Date________