



Junction City Medical Clinic Patient Registration Form

355 W. Third Ave

Junction City, OR 97448

Phone: 541-998-6750 Fax: 541-998-1247

PLEASE PRINT & COMPLETE ALL SECTIONS

Patient's Legal Name (Last, First, Middle) Sex Date of Birth Social Security Number

Mailing Address (Street/City, State, Zip) Parent/Guardian (if under 18 yrs)

Physical Address (if different) Spouse Name

Home Phone Cell Phone Work Phone Email Address

Employer Employer Phone Spouse Employer Spouse Employer Phone

Ethnicity (circle one) White Hispanic Black/African American Native American Asian Pacific Islander Other

Primary Insurance Subscriber Subscriber Date of Birth Subscriber Soc Sec Number

Secondary Insurance Subscriber Subscriber Date of Birth Subscriber Soc Sec Number

EMEGENCY CONTACTS

Relative: _____ Relationship: _____ Phone(s): _____

Non-Relative: _____ Relationship: _____ Phone(s) _____

RELEASE OF INFORMATION: I give permission to the following persons to have access to my medical records and information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

CONSENT FOR TREATMENT

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

Signature: _____ Date: _____

If fifteen years or older, patient must sign and aurthorize the above information.