



**FALL CREEK
INTERNAL MEDICINE**

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

Kathryn K. Kocurek MD
Patricia A. Nibler MD
Kristin M. VanDomelen MD
Brittany Leila Perry, MD
Jessica Jensen PA-C
Phone: 541-389-1118
Fax: 541-389-2662

PATIENT INFORMATION/REGISTRATION

PATIENT NAME		DOB	MARITAL STATUS	SOCIAL SECURITY #	DRIVERS LICENCE #
			S M DP D W		
ADDRESS			CITY	STATE	ZIP CODE
PRIMARY PHONE	OK to Leave a Message		Appointment Confirmation Calls		
	<input type="checkbox"/> BRIEF <input type="checkbox"/> DETAILED		<input type="checkbox"/> TEXT MESSAGE <input type="checkbox"/> VOICE		
SECONDARY PHONE	OK to Leave A Message		Appointment Confirmation Calls		
	<input type="checkbox"/> BRIEF <input type="checkbox"/> DETAILED		<input type="checkbox"/> TEXT MESSAGE <input type="checkbox"/> VOICE		
EMAIL Address				PATEINT PORTAL ACCESS	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
EMERGENCY CONTACTS					
NAME		RELATION		PHONE NUMBER	
INSURANCE INFORMATION (Complete ALL Sections)					
PRIMARY INSURANCE					
INSURANCE NAME					
PATIENT ID NUMBER				GROUP NUMBER	
SECONDARY INSURANCE					
INSURANCE NAME					
PATIENT ID NUMBER				GROUP NUMBER	



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Employment Status		<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed
EMPLOYER			OCCUPATION			
SEXUAL ORIENTATION:			GENDER IDENTITY			
Do you think of yourself as?		Do you think of yourself as?		What sex was originally listed on your birth certificate?		
<input type="checkbox"/> Straight or Heterosexual	<input type="checkbox"/> Something else; please specify: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Male		
<input type="checkbox"/> Lesbian or Gay	_____	<input type="checkbox"/> Transgender man/trans man	<input type="checkbox"/> Transgender woman/trans woman	<input type="checkbox"/> Female		
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Genderqueer/gender nonconforming neither exclusively male nor female.	<input type="checkbox"/> Additional gender category (or other); Please specify: _____	<input type="checkbox"/> Decline to answer		
<input type="checkbox"/> Queer, Pansexual, and/or questioning.	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Decline to answer				
PREFERRED PRONOUN(S)						
RACE		ETHNICITY		LANGUAGE	TRANSLATOR	
<input type="checkbox"/> American Indian /Alaska Native	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> English	<input type="checkbox"/> YES	
<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Unreported/Refused to Report		<input type="checkbox"/> Spanish	<input type="checkbox"/> NO	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Other Race			<input type="checkbox"/> Russian		
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Unreported/Refused to Report			<input type="checkbox"/> Indian		
				<input type="checkbox"/> Other _____		

By signing below, I acknowledge that the information I provided is correct to the best of my ability. I hereby authorize FCIM to release to my Health Insurance carrier any information acquired in the course of my examination or treatment including medical records, test results, and billing information.

NAME: _____

DATE _____