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 LICENSE #
		S M DP D W		

ADDRESS	CITY	STATE	ZIP CODE

PRIMARY PHONE	OK to Leave a Message	Appointment Confirmation Calls
	□ BRIEF □ DETAILED	□ TEXT MESSAGE □ VOICE

SECONDARY PHONE	OK to Leave A Message	Appointment Confirmation Calls
	□ BRIEF □ DETAILED	□ TEXT MESSAGE □ VOICE

EMAIL Address	PATEINT PORTAL ACCESS
	□ YES □ 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	□ Full-time	□ Part-time	□ Self-employed	□ Retired	□ 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?**
□ Straight or Heterosexual □ Lesbian or Gay □ Bisexual □ Queer, Pansexual, and/or questioning. □ Something else; please specify: _____ _____ _____ □ Don't Know □ Decline to answer	□ Male □ Female □ Transgender man/trans man □ Transgender woman/trans woman □ Genderqueer/gender nonconforming neither exclusively male nor female. □ Additional gender category (or other); Please specify: _____ □ Decline to answer	□ Male □ Female □ Decline to answer

PREFERRED PRONOUN(S)			
RACE	**ETHNICITY**	**LANGUAGE**	**TRANSLATOR**
□ American Indian /Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ Black or African American □ White □ Hispanic □ Other Race □ Unreported/ Refused to Report	□ Hispanic or Latino □ Not Hispanic or Latino □ Unreported/Refused to Report	□ English □ Spanish □ Russian □ Indian □ Other _____	□ YES □ NO

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 _____