



**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
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		
	<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"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer, Pansexual, and/or questioning.			<input type="checkbox"/> Something else; please specify: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Decline to answer		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender man/trans man <input type="checkbox"/> Transgender woman/trans woman <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	
PREFERRED PRONOUN(S)						
RACE			ETHNICITY		LANGUAGE	TRANSLATOR
<input type="checkbox"/> American Indian /Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American			<input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Race <input type="checkbox"/> Unreported/Refused to Report		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Indian <input type="checkbox"/> Other _____	<input type="checkbox"/> YES <input type="checkbox"/> 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 _____