Fax to 541-302-6473

Today's Date:	Primary Care Physician: Referring Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:

Cell Phone ( )	Home phone ( )	Birth date:	Sex: ☐ M ☐ F

Mailing address:

City:	State:	ZIP Code:

Patient's Contact Preference: It's okay to leave a message ☐Cell only ☐Don't call at home ☐ Don't call at work ☐No message please ☐ Home only Other:

Reason for visit / Dx:

INSURANCE INFORMATION

Is this patient covered by insurance?	☐ Yes ☐ No
Please indicate primary insurance	☐ [Insurance]

☐Please include pathology, pertinent scan reports, pertinent visit notes unless obtainable on line.
☐On line through Centricity Live