Oasis Center of the Rogue Valley
Registration From

If you need help filling out these forms, please don't hesitate to ask staff for assistance!

Patient Information

Name: ____

Preferred Name: ____________________________________SSN: ____________________________

Date of Birth: _______________________________ Gender: M F

Mailing Address: ____

City: ___________________________________ State: ____________________ Zip: _____________

Primary Phone: ________________________

Email Address: ________________________________

Language: ___________________________ Do you need an interpreter? Yes No

Primary Care Provider: ____

Responsible Party – *who is responsible for bills and insurance?*

____ Same as Patient

Responsible Party: ____ SSN: _____________________

Address: ____

Phone: __________________________________ Relationship to Patient: _____________________

Health Insurance Information – *please fill out as much information as you know, if possible, please provide insurance card to front desk. If you are uninsured we can help you sign up for OHP/Medicaid.*

Primary Insurance: ____
Member ID: ____ Group #: _______________________
Effective date: ____________________ Subscriber Name: ___________________________________
SSN: ____________________________ DOB: __________________________________
Subscriber Address: ____

Secondary Insurance: ____
Member ID: ____ Group #: _______________________
Effective date: ____________________ Subscriber Name: __________________________________
SSN: ____________________________ DOB: __________________________________
Subscriber Address: ____

Work related injuries: Date of injury: _________________ Injury/Accident insurance carrier: ________
Claim/Auth: __________________

How did you hear about the Oasis Center?

___ Friend ___ Word of mouth ___ Community flyer ___ Residential Treatment

___ Child Welfare ___ Community Justice ___ Other: ________________________

Is there anything you would want us to know? – *example current medications, what services are you looking for, or any other information you would want us to know.*

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments
____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.
____ I authorize you to leave a message with anyone who answers the phone
____ Messages may only be left with ____

____ ___________________
Patient Name (PLEASE PRINT) **Date**

____ ___________________
Patient Name Signature **Date**

Office Use:

Insurance Verified: ____

Personal Clinician assigned: ____