Oasis Center of the Rogue Valley
Registration

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 ____ Prefer not to answer_____ Language: __________ Do you need an interpreter? Yes No

Mailing Address: ____

City: ____________________________________ State: ____________________ Zip: _____________

Primary Phone: _________________________ Email Address: ____

Who is your current Primary Care Provider? ____

Marital Status: ____________________ City of Birth: ____________________________________

Employer Name (or N/A): __________________________________ Full-Time or Part-Time (circle one)

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

____ Same as Patient

Responsible Party: ____ SSN: ______________________

Address: ____

Phone: ___________________________________ Relationship to Patient: ______________________

Emergency Contact Information

Emergency Contact Name (1): ____

Relationship: ____________________________ Contact #: ____

Emergency Contact Name (1): ____

Relationship: ____________________________ Contact #: ____

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: ________________________ or provided SFS: _________________________________

Personal Clinician assigned: ____