PATIENT INFORMATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Have you previously been seen by Mason Harrison FNP-C? _____ Yes _____ No

Patient Name Today's Date Date of Birth Gender Age
Parent if Patient is a Minor
Patient's Social Security Number Oregon Driver's License No.
Home Address City State Zip
Mailing Address if Different City State Zip
Primary (Best) Telephone Number Secondary Telephone Number May we leave a message? (If blank the assumption is Yes) _____ NO
Occupation Employer's Name
May we contact you at work? (If Blank the assumption is Yes)
Race: Decline _____ White _____ American Indian/Alaska Native _____ Nat Hawaiian/Pac Isl _____ Asian _____ Black/African American _____ Or Other _____ Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Declined _____
Emergency Contact Name/Number and Relationship
We now have Patient Portal Please list email address _____
Preferred Pharmacy:
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES
Name Telephone
Address City State Zip
Primary Insurance Company Claim Address
Subscriber's Name Subscriber's Date of Birth Relation to Patient
Insurance ID No.:
Is a referral required: YES NO Is a copay required: YES NO
Secondary Insurance Company Claim Address
Subscriber's Name Subscriber's Date of Birth Relation to Patient
Insurance ID No.:
Is a referral required: YES NO Is a copay required: YES NO
Were You Injured on the Job? YES NO Have you Informed Your Employer? YES NO
Date of Original Injury:
Worker's Compensation Carrier Name Address: