orchid health
wade creek clinic

535 NE 6th Ave., Estacada, OR 97023
Office: (503) 630-8550
Fax: (503) 862-5060

WADE CREEK CLINIC REGISTRATION FORM

(Please print)

First Name: _____ Last: _____ Middle: _____ Sex: _____

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name: _____
Former name: _____

DOB:_____ Age: _____ Social Security Number: _____

Home Phone: ( ) Mobile Phone: ( ) Email:
Preferred communication method:

Mailing Address: _____ City: _____ State: _____ ZIP Code: _____
Occupation: _____ Employer: _____ Employer Phone #: ( )

Race: _____ Ethnicity: _____Preferred Language: _____

Emergency Contact (name, relationship, phone #): _____

Current Medical Provider/Primary
Care:_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance type: _____
Subscriber Information:
Name: _____ SSN: _____ DOB: _____
Group no: _____ Policy no: _____ Co-payment: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): _____
Subscriber Information:
Name: _____ SSN: _____ DOB: _____
Group no: _____ Policy no: _____

Person responsible for bill:
Name: _____ SSN: _____ DOB: _____

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Address: _____ Phone #:

_____