Ryan R. Stevens, M.D., P.C.
1867 N.W. Kings Blvd.
Corvallis, OR 97330

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit.
Please present your insurance card and photo ID for copying, as well as completing the information below.
CO-PAY IS DUE ON DATE OF SERVICE

Name_____
Last First MI Nickname

Date of Birth:_____ Marital Status: (circle one) Single Married Divorced Separated Widowed

Sex: (circle one) Male Female E Mail:_____

Home Address:_____
Street City State Zip

Home Phone: ( ) _____-_____ Cell/Message Phone: ( ) _____- _____

Mailing Address:_____ _____
Street/PO Box City State Zip

Employer: _____ Work Phone: ( ) _____-_____

Spouse/Parent Name:_____

Spouse/Parent Employer:_____ Work Phone: ( ) _____-_____

If someone OTHER THAN THE PATIENT is responsible for payment, complete the following:
Name of the responsible party:_____ Address:_____
Relationship to patient: _____ Home Phone: ( ) _____-_____
Employer:_____ Address:_____ Work Phone:( ) ____-_____

In case of EMERGENCY:
Relative to Contact (other than spouse: _____ Phone: ( )_____-_____
Other person to contact (not relative): _____ Phone: ( )_____-_____

Please complete the following information regarding your medical insurance:
Primary Insurance Co :_____ Phone:( ) _____-_____
Name of Insured:_____Policy #_____Group#_____

Reason for this visit: Illness ___ Injury ___ Job related injury ___ Auto Accident ____ Other ___

Date of injury or onset of problem____/____/____

Explain symptoms _____

Please answer the following questions, sign and date.

I give my permission for messages concerning my personal healthcare to be left on my answering machine or voicemail or with someone other than myself: _____Yes _____No

May our office confirm appointments, or leave a message at your home with someone other than yourself if needed? _____ Yes _____No

Signature:_____ Date:_____