ASHLAND FAMILY PRACTICE

935 Siskiyou Blvd. Ashland, OR 97520-2143
Phone: 541 482 2716 Fax: 541 488 5461
Cynthia Parks-Landis, F.N.P. Jennifer Moss, F.N.P.

Patient Information

Today's Date: _____

Last Name: _____ **First:** _____ **Middle:** _____ **Preferred Name:** _____

Social Security #: _____ **Date of Birth:** _____ **Gender:** ☐ F ☐ M ☐ Other

What is the reason for your visit today? _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____ **Email:** _____

Employer: _____ **Occupation:** _____ **Work Phone #:** _____

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work ☐ Portal(coming soon) **Voice/Text Message Ok?** ☐ Home ☐ Cell ☐ Work

Responsible Party Name: _____ DOB: _____ SSN: _____

***Primary* Insurance Company:** _____ Policy #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SSN: _____

***Secondary* Insurance Company:** _____ Policy #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SSN: _____

Preferred Local Pharmacy: _____ Location: _____

Preferred Mail Order Pharmacy: _____ Policy #: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

If you are requesting to become a new patient, please answer the additional questions below: *Provider requesting:* ☐ *Cynthia (Cindy) Parks-Landis, FNP* ☐ *Jennifer Moss, FNP*

List any chronic medical conditions & allergies you have: _____

_____

List any prescribed medications & vitamins/supplements you are taking: _____

_____

Referred by: _____ ***Previous physician:*** _____ ***Date of last physical exam:*** _____

Please allow us one week to respond to this inquiry. Thank you