



# 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.*  
*Rebecca Bolling, 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: \_\_\_\_\_

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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  Rebecca Bolling, 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