Jon E. L. Ermshar, MD
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Grants Pass, OR. 97527
541-474-6053
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Patient: _____
Last name First Name Middle Initial

Sex: _____ Name of Spouse: _____

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____SSN:_____ Home Phone_____

Business Phone: _____ Cell Phone: _____

Patient Employed By: _____ Preferred Pharmacy_____

Race (Please circle one): White, American Indian, Asian, Black/African American, Hawaiian/Pacific Islander or Other Race

Ethnicity (Please circle one): Hispanic/Latino, **Non**-Hispanic/Latino, Declined

Tobacco Status (Please circle one): Current, Former or Never

If Patient Is A Minor:

Father's Name _____ DOB _____ SSN_____

Address _____ Phone _____

Mother's Name_____ DOB _____ SSN_____

Address _____ Phone _____

Name of Primary Insurance _____

Subscriber's Name _____ ID# _____ Grp# _____

Nearest Relative or Friend not living at your address

Name _____ Phone_____ Relationship _____

Previous Doctor _____

Patients are responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. I authorize Jon E.L. Ermshar M.D. to release to my insurance company or its intermediaries, any information needed for insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization remains in effect unless a request by the patient is received in writing.

Signature _____ Date_____

ACKNOWLEDGEMENT AND CONSENT

I understand that WellSpring Family Practice will use and disclose health information about me.
I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that this practice may use and disclose my health information as described in a Notice of Privacy Practices.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices which are available at the front desk.

By:_____DOB:_____Date:_____
(Patient or authorized signature if under 18 years of age)