Jon E. L. Ermshar, MD	1716 Williams Hwy	Brett Rasmussen, PA
Gail Giltner, FNP	Grants Pass, OR. 97527	Kelsey Brangoccio, PA
Erin Winn, PA	541-955-0607	
	Fax 541-474-4527	

Patient: ____
Last name (including maiden name) First Name Middle Initial

Sex: ______________ Name of Spouse: ____

Mailing Address: ____

Street Address: ____

City: __________________________ State: _________________________ Zip: ____________________

Date of Birth: __________________SSN:_______________________

Patient Employed By: _____________________________ Preferred Pharmacy_____________________

Home Phone________________________________ Business Phone: _______________________

Cell Phone: _________________________ Email address: ______________________________________

- Please mark which method of contact is your preferred contact for appointment reminders.

  ☐ Home phone ☐ Cell phone ☐ Email ☐ Decline to have reminders

- If you are interested in the Patient Portal which will allow you to access your account to make payments, schedule appointments, or ask a question for the medical staff please make sure to give us your email address above and initial here ***(OPTIONAL)***: _______

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

Name of Primary Insurance ____

Subscriber's Name ___________________________ DOB _________ID# ___________________ Grp# ________

If Patient Is A Minor:

Father's Name ____________________________________ DOB ___________ SSN__________________

Address ____ Phone __________________________

Mother's Name____________________________________ DOB ____________ SSN__________________

Address ____ Phone __________________________

Nearest Relative or Friend not living at your address:

Name _________________________________ Phone________________ Relationship _______________

Previous Doctor ____

By supplying my home phone number, cell phone, email address, and any other contact information, I authorize WellSpring Family Practice to employ a third-party automated outreach and messaging system to use my contact information to make appointment reminder calls via text, phone and email. I also authorize my healthcare provider to disclose to third parties who may intercept these messages limited protected health information for the purpose of notifying me of a pending appointment, the time and place of my appointment, or missed appointment. ________ Initial

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)

Clinical Research: Wellspring Family Practice is conducting different clinical research projects. We can contact you if you are interested in receiving information or to participate in a Clinical Trial, please indicate by signing below:

____

Signature if you are interested in participating in a Clinical Trial ***(OPTIONAL)***