Grants Pass Clinic, L.L.P.
495 SW Ramsey Avenue • Grants Pass, Oregon 97527 • 541-476-6644

NEW PATIENT REQUEST

Before completing this form, please be advised of the following:

- Grants Pass Clinic does not provide chronic pain medications and does not prescribe narcotics.
- New patients are accepted based on meeting certain criteria established by Grants Pass Clinic, including health insurance coverage.

*** New patient requests may take 2-4 weeks' processing time. Incomplete applications will add delay. ***
You will be notified by mail of your application status.

PERSONAL INFORMATION

Applicant's Last Name	First Name & Middle Initial	Date of Birth	I identify as ❑ M ❑ F ❑ _____
Other last name(s) used:			
Address		City, State, Zip	
Home Phone ☐ *Primary contact*		Mobile Phone ☐ *Primary contact*	
Relationship to applicant (e.g., parent/guardian*/conservator*/foster*): Self ☐ Other _____ * Court documents must be attached.	Guarantor Last Name	Guarantor First Name	Guarantor DOB
Requested Provider 1st Choice	2nd Choice	3rd Choice	
Reason for establishing care?			
How did you hear about us?			
Are you returning to Grants Pass Clinic? Yes ☐ No ☐	Have you ever been involuntary discharge from any medical practice? *Yes* ☐ *No* ☐ If yes, from what practice and why?		

INSURANCE INFORMATION ****Attach a copy of your insurance card(s)*

❑ Medicare or Medicare Advantage ❑ Oregon Health Plan or AllCare ❑ Private or Employer Group Health Plan
❑ Uninsured/Self-pay

Primary Insurance Carrier	Member ID#	Group #
Subscriber Name	Subscriber Date of Birth	Group Name
Secondary Insurance Carrier	Member ID#	Group #
Subscriber Name	Subscriber Date of Birth	Group Name

HISTORY OF MEDICAL CARE

Are you **currently** taking a controlled substance (Ultram, Norco, Percocet, Vicodin, Ritalin, Adderall, Vyvance or Benzodiazepines, such as Xanax, Klonopin, Ativan, Valium, etc)? Yes ☐ No☐

If yes, what is the name of the controlled substance: _____

Have you even been diagnosed with chronic pain requiring regularly schedule controlled substance: Yes ☐ No ☐

If prescribed by a chronic pain management practice, what is clinic where you are a patient? _____

List of all medications / supplements you are presently taking, including the dosage and number of times taken per day:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

List of all medical illness (for example diabetes, hypertension, asthma):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

☐ I consent to receive telephone calls and voicemails in response to this request, delivered to the telephone number(s) I have provided verbally and/or in writing to Grants Pass Clinic.

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT

Patient/Authorized Signer: _____ Date: _____

Grants Pass Clinic does not and shall not discriminate on the basis of race, color, religion, gender, gender identity, age, national origin, disability, marital status, or genetic information.

Please mail, fax, or drop off your completed form:

Grants Pass Clinic
495 SW Ramsey Ave.
Grants Pass, OR 97527
Fax 541-472-5673

For Office Use Only:

Appointment: ❑ Yes ❑ No MRN: _____