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.

PERSONAL INFOMATION

Patients Last Name:		First Name:		Middle Int:	M F
Address:				Date of Birth:	
City:	State:	Zip:	SS#		
Primary Phone:		Alternate Phone:			
Relationship to patient: Self ☐	Last Name:	First Name:	Middle Int:	Date of Birth:	
Requested Provider 1st Choice:	2nd Choice:	3rd Choice:			
Reason for establishing care:					
How did you hear about us:					
Have you ever been discharged from another medical practice? Yes ☐ No ☐	If yes, what is the name of the practice you were discharged from?				
Why were you discharged?					

INSURANCE INFORMATION

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 yes, what is the name of the Chronic Pain Management clinic where you are a patient? _____

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

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

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. _____

☐ 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: _____

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