Wallowa Memorial Medical Clinic

We Treat You Like Family

Phone: 541-426-7900 Fax: 541-426-7920

Email: clinic.registration@wchcd.org

Which Wallowa Memorial Medical Clinic Provider would you prefer to see?

_____

Full Name: _____ DOB: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Gender: _____ Social Security No.: _____ Language: _____

Current Employer: _____

Blind/Low Vision? YES ☐ NO ☐

Marital Status (please select one): Married

Deaf/HoH? YES ☐ NO ☐

Interpreter Needed? YES ☐ NO ☐

Preferred Language: _____

Ethnicity: ☐ Hispanic or Latino ☐ Unknown ☐ Not Hispanic or Latino ☐ Decline

Race: ☐ White or Caucasian ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ Unknown ☐ Decline

Other: _____

Who is your current doctor? _____
Name *Phone* *Address*

Do you have immediate medical issues you need addressed? ☐ YES ☐ NO ☐ UNKNOWN

Have you ever seen a specialist before? ☐ YES ☐ NO ☐ UNKNOWN

Are you currently on a pain contract? ☐ YES ☐ NO ☐ UNKNOWN

Are you taking ANY medication for pain? If yes, please list below:

_____

_____

Are you taking any ADHD medication? ☐ YES ☐ NO ☐ UNKNOWN

Guarantor Information (party responsible for billing)

If you are patient AND guarantor please put "SELF" and skip to Guarantor Employment section.

Full Name: _____ DOB: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Relationship to Patient: _____ SSN.: _____

(if different than listed above)

Phone Number: _____

Self Employment

Company: _____ Position: _____

Address: _____ Phone: _____

Status (Please select one): Full-Time

Guarantor Employment (if different then Self)

Company: _____ Position: _____

Address: _____ Phone: _____

Status (Please select one): Full-Time

Insurance Coverage Information 1

Name of Insurance: _____ Patient Relationship to Subscriber: _____

Group #: _____ Subscriber ID#: _____

Insurance Subscriber Information 1

Name of Insurance: _____ Patient Relationship to Subscriber: _____

Group #: _____ Subscriber ID#: _____

Insurance Coverage Information 2

Name of Insurance: _____ Patient Relationship to Subscriber: _____

Group #: _____ Subscriber ID#: _____

Insurance Subscriber Information 2

Name: jane _____ Subscriber ID#: _____

Address: _____ Phone #: _____

Patient Relationship-Emergency Contact 1
(will not have access to your medical records)

Name: _____ Phone: _____

Relation to patient: _____

Patient Relationship-Emergency Contact 2
(will not have access to your medical records)

Name: _____ Phone: _____

Relation to patient: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Wallowa Memorial Medical Clinic
We Treat You Like Family
601 MEDICAL PARKWAY- ENTERPRISE, OREGON 97828
PHONE: 541-426-7912 - **FAX: 541-426-7920**
clinicregistration@wchcd.org

PATIENT INFORMATION

PRINT Patient Name: _____

Birth Date (mm/dd/yyyy):_____

Phone#:_____

Mailing Address: _____

City: _____State:_____Zip:_____

Email: _____

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

1. I AUTHORIZE THE FOLLOWING PERSON(S) OR ENTITIES TO RELEASE MY PROTECTED HEALTH INFORMATION:

From:_____

Address/Phone:_____

Fax#:_____

RELEASE HEALTH INFORMATION TO:
Wallowa Memorial Medical
601 Medical Parkway
Enterprise, OR 97828
Phone: 541-426-7912
Fax: **541-426-7920**

PURPOSE OF RELEASE:
☐ TRANSFER OF CARE
☐ REFERRAL/CONSULT
☐ OTHER:

2. INFORMATION I AUTHORIZE TO BE RELEASED:

☐ ALL RECORDS FOR THE DATE RANGE OF: _____

☐ Medical Records
☐ Immunizations
☐ Pharmacy Records
☐ Radiology Records
☐ Radiology Images
☐ Other:_____

3. INFORMATION REGARDING THE FOLLOWING WILL ONLY BE RELEASED IF *INITIALED* BY PATIENT.

Please ***INITIAL*** each line listed below:

___HIV INFECTION
___DRUG/ALCOHOL ABUSE TREATMENT RECORDS
___MENTAL HEALTH
___GENETIC TESTING

I understand that if the person(s) or entity(s) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-released and is no longer protected by those regulations. Therefore, I release Wallowa Memorial Medical Clinic, its employees, and physicians from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in **90 days** from the date signed below. I understand that I may revoke this authorization by notifying in writing the Health Information Management Department knowing that previously disclosed information would not be subject to my revoke request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits.

_____ _____
Signature of patient or legal representative **Date**

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness **Date**

OFFICE STAFF ONLY: THIS RELEASE IS VALID UNTIL: _____, MEDICAL RECORD NUMBER: _____

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For provider review, are you taking any of the following medications? (Please check all that apply)

☐ Morphine	☐ Hydrocodone	☐ Oxycodone
☐ Fentynl	☐ Tramadol	☐ Oxycotin
☐ Norco	☐ Lunesta	☐ Aderall
☐ Lorazepam	☐ Alprazolam	☐ Ativan

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Patient Pharmacy Options

Safeway Pharmacy
601 W North Street
Enterprise, Or 97828
541-426-3535

Hours:
Monday - Friday
8:00 AM-1:30 PM,
2-6 PM
Saturday
9:00 AM-1:30 PM,
2-5 PM

Red Cross Drug Store
1123 Adams Ave.
La Grande, OR 97850
541-963-5741

Hours:
Monday - Friday
9:00 AM-6:00 PM
Saturday
9:00 AM-2:00 PM

Walmart Pharmacy
11619 Island Ave.
Island City, OR 97850
541-963-5460

Hours:
Monday - Saturday
9:00 AM-7:00 PM,
Sunday
10:00 AM-6:00 PM

Rite Aid Pharmacy
2212 Island Ave.
Ste. 201
La Grande, OR 97850
541-963-8696

Hours:
Monday - Saturday
8:00 AM-1:30 PM,
2-9 PM
Sunday
9:00 AM-1:30 PM,
2-7 PM

Mail order prescriptions available!

Mail Order Pharmacy Options

Express Scripts
1-800-282-2881
24 hours, 7 days a week

CVS Caremark
1-800-552-8159
Pharmacist is available during normal business hours