Wallowa Memorial Medical Clinic

We Treat You Like Family

Phone: 541.426.7900
Email: Clinic.Registration@wchcd.org

Health Information

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

Who is your current doctor? Please provide their contact information:

Name: _____ Phone: _____

Address: _____

Which Wallowa Memorial Medical Clinic provider do you prefer to see? _____

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** medications for pain? If yes, please list below:

_____

_____

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: _____

Phone Number: _____

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Guarantor Employment (Party Responsible For Billing)

Company: _____ Position: _____

Address: _____ Phone: _____

Status: ☐ Full Time ☐ Disabled ☐ Student ☐ Unemployed
☐ Part Time ☐ Self-Employed ☐ Retired

Primary Insurance Information:

Name of Patient: _____

Name of Insurance: _____ Group #: _____

If applicable, please fill in the insurance subscriber's information below. The subscriber is the person who holds the insurance plan.

Name of Subscriber: _____ Subscriber DOB: _____

Patient Relationship to Subscriber: _____ Subscriber ID#: _____

Secondary Insurance Information:

Name of Patient: _____

Name of Insurance: _____ Group #: _____

If applicable, please fill in the insurance subscriber's information below. The subscriber is the person who holds the insurance plan.

Name of Subscriber: _____ Subscriber DOB: _____

Patient Relationship to Subscriber: _____ Subscriber ID#: _____

Emergency Contact 1

Your emergency contact will not have access to your medical records.

Name: _____ Phone: _____

Relation to Patient: _____

Emergency Contact 2

Your emergency contact will not have access to your medical records.

Name: _____ Phone: _____

Relation to Patient: _____

Signature

Patient Signature: _____ Date: _____

Required if form was completed by a legal guardian or authorized representative:

Print Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

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Patient Contact Information

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

SSN: _____ Phone: _____ Email: _____

Address:

_____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Patient Demographics

Why do we ask for your demographic information?
To help us better understand your healthcare needs, we need to know some things about you, like your race, language, gender, and ability levels. While we hope you answer these questions, you can select "Don't know" or "Don't want to answer." Your responses are confidential.

Deaf/Hard of Hearing?
☐ Yes
☐ No

Blind/Low Vision?
☐ Yes
☐ No

Marital Status:
☐ Married
☐ Domestic Partner
☐ Separated
☐ Significant Other
☐ Single
☐ Widowed
☐ Other:_____

Preferred Language:
_____

Interpreter Needed?
☐ Yes (If yes, confirm what language your interpreter should speak: _____)
☐ No

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Don't know
☐ Don't Want to Answer

Race:
☐ Alaska Native
☐ American Indian
☐ Asian
☐ Black or African American
☐ Chicano/a or Chicanx
☐ Chinese
☐ Mexican/Mexican American
☐ Middle Eastern
☐ Pacific Islander
☐ White/Caucasian
☐ Other: _____
☐ Don't Know
☐ Don't Want to Answer

Sex Assigned At Birth:

☐ Female
☐ Male
☐ Don't Know
☐ Don't Want to Answer

If you are 12 years old or younger, skip to SIGNATURE section.

Legal sex: (per your ID)

☐ Female
☐ Male
☐ Other: _____
☐ Don't Know
☐ Don't Want to Answer

Pronouns:

☐ He/Him/His
☐ She/Her/Hers
☐ They/Them/Theirs
☐ Other: _____

Gender Identity: (Select One)

☐ Female
☐ Male
☐ Agender
☐ Demiboy
☐ Demigirl
☐ Gender Fluid
☐ Genderqueer
☐ Non-binary
☐ Transgender Female
☐ Transgender Male
☐ Two Spirit
☐ Other: _____
☐ Don't Know
☐ Don't Want to Answer

Sexual Orientation: (Select One)

☐ Asexual
☐ Bisexual
☐ Gay
☐ Lesbian
☐ Pansexual
☐ Queer
☐ Straight
☐ Other: _____
☐ Don't Know
☐ Don't Want to Answer

Signature

Patient Signature: _____ Date: _____

Required if form was completed by a legal guardian, authorized representative, or caretaker:

Print Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

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Authorization of Release of Medical Information

Phone: 541-426-7900 **Email:** Clinic.Registration@wchcd.org **Fax:** 541-426-7901

Patient Information

Patient Name: _____ DOB: _____

Mailing Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: _____ Email: _____

Authorization

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 Clinic
601 Medical Parkway
Enterprise, OR 97828
Phone: 541-426-7900
Fax: 541-426-7901

PURPOSE OF RELEASE:
- ☐ Transfer of Care
- ☐ Referral/Consult
- ☐ Other: _____

2. Information I authorize to be released:

- ☐ ALL RECORDS
- ☐ Medical Records
- ☐ Immunizations
- ☐ Pharmacy Records
- ☐ Radiology Records
- ☐ Radiology Images
- ☐ Other: _____

For the date range of: _____

3. Information regarding the following will only be released if *initialed* by the patient. Please *initial* each line below:

____ HIV Infection

____ Mental Health

____ Drug/Alcohol Abuse Treatment Records

____ Genetic Testing

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Authorization of Release of Medical Information

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
☐ Fentanynl	☐ Tramadol	☐ OxyContin
☐ Norco	☐ Lunesta	☐ Adderall
☐ 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