

**Ryan R. Stevens, M.D., P.C.**  
**1867 N.W. Kings Blvd.**  
**Corvallis, OR 97330**

**PATIENT INFORMATION**

*Completion of this information in its entirety is required at time of visit.*

*Please present your insurance card and photo ID for copying, as well as completing the information below.*

CO-PAY IS DUE ON DATE OF SERVICE

Name \_\_\_\_\_  
Last First MI Nickname

Marital Status: (check one) Single Married Divorced Separated Widowed

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male Female

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell/Message Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street/PO Box City State Zip

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Spouse/Parent Employer \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party \_\_\_\_\_ Address \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

In case of EMERGENCY:

Relative to Contact (other than spouse) \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Other person to contact (not relative) \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Please complete the following information regarding your medical insurance:

Primary Insurance Co. \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Name of Insured \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_

**Reason for this visit:** Illness \_\_\_ Injury \_\_\_ Job related injury \_\_\_ Auto Accident \_\_\_ Other \_\_\_

Date of injury or onset of problem \_\_\_/\_\_\_/\_\_\_

Explain symptoms \_\_\_\_\_

**Please answer the following questions, sign and date.**

*I give my permission for messages concerning my personal healthcare to be left on my answering machine/voicemail or with someone other than myself: \_\_\_Yes \_\_\_No*

*May our office confirm appointments, or leave a message at your home with someone other than yourself if needed? \_\_\_Yes \_\_\_No*

Signature \_\_\_\_\_ Date \_\_\_\_\_