Integrative Family Medicine of Bend

Patient Registration

Patient Information

Legal First Name

Legal Last Name

Preferred Name

DOB

Sex at Birth

◯ Female ◯ Male

Marital Status

Mobile Phone

Home Phone

Email

Address

Suite/Apt. #

City

State

Zip

Race

Ethnicity

Please print a picture of your driver's license, front and back.

Emergency Contact Information

First Name

Last Name

Relationship

Phone

Pharmacy Information

Name of your Pharmacy

Phone #

Address, City, State, Zip

Insurance

Do you have insurance?

◯ Yes ◯ No

Primary Insurance Company

Member ID / Policy #

Group ID

Policy Holder's First Name | Policy Holder's Last Name | Policy Holder's Date of Birth

Please print a picture of your insurance card, front and back.

Do you have additional insurance?

◯ Yes ◯ No

Secondary Insurance Company | Member ID / Policy # | Group ID

Policy Holder's First Name | Policy Holder's Last Name | Date of Birth

Please print a picture of your seconday insurance card, front and back.