West Hills Health Care Clinic
2163 NW 2nd Street
McMinnville, Oregon 97128
Phone (503) 472-4197 FAX (503) 434-2886

Thank you for your interest in becoming a patient at West Hills Healthcare Clinic. We are honored that you would choose us for your health needs. We take very seriously the healthcare of our patients and want to provide the very best care for everyone.

Our doctors have asked to review our potential patient's health history and medical concerns before accepting them as new patients to West Hills Health Care. This allows our providers to identify those patients whose health circumstances or complexity of care may not be best suited for a family practice clinic. Please fill in the requested information below and return it to us in person, by mail, email, or fax. Newpatient@westhillshealthcare.com

Our providers will review your information within 7-10 business days. Your health information is kept private and will be retained only if you become a patient at this clinic. We appreciate your time spent providing this information. Failure to fill this form out completely may delay the approval process. Appointments can be scheduled after application approval.

First Name: ______________________________ Middle Initial: ______ Last Name: ______________________________

Name of Parent or Legal Guardian if under 18: ____

Mailing Address: ____

____

Email address: ____

Primary Phone #: ________________________________Secondary Phone #: ________________________________

SSN: _______ - ______ - ________ Date of birth: ____

Birth Sex: ____________ Marital status: ________________________ Preferred Language: _____________________

Emergency Contact Name and Relationship: ____

Emergency Contact Phone #: ____

<u>Medical Information</u> (The following questions <u>must</u> be answered. If the question doesn't apply, write 'None')

Current medical concerns? ____

Current medications? ____

CHRONIC medical issues? ____

CHRONIC issue/maintenance medications? ____

Previous Hospitalizations/Surgeries/Other medical conditions? ____

List questions or concerns you might wish to discuss at your first appointment:

1. ____

2. ____

3. ____

How did you hear about West Hills Healthcare? ____

Which family members patients of West Hills Healthcare? ____

Requested Provider: (Write “Any” if no preference) ____

Who is your current Primary Care Provider? ____

INSURANCE INFORMATION

Please make sure to provide the name of the insurance company/carrier (BCBS, United Healthcare, etc.) rather than the name of the business you work for which provides your insurance.

Primary Insurance-

Name of insurance company: ____ Effective date: _____________

ID/Policy #: _______________________Group #:________________Co-Pay amount: ____________

Subscriber information:

Name: ____ Date of Birth: ________________

Relationship to Patient: _____________________________ SSN: _______ - ______ - ___________

Address: ____

Secondary Insurance-

Name of insurance company: ____ Effective date: _____________

ID/Policy #: _______________________Group #:________________Co-Pay amount: ____________

Subscriber information:

Name: ____ Date of Birth: ________________

Relationship to Patient: _____________________________ SSN: ________ - _______ - _________

Address: ____

Please understand that regardless of your insurance status, you are ultimately responsible for the charges incurred by you and your dependents for professional service rendered.