GRANTS PASS FAMILY MEDICINE PC

Employee
Member Registration

Last Name: ______________________ Suffix: ____ First Name: ______________________Middle Initial:___

Date of Birth: ______________________ O Male O Female

Home Address: _______________________________ City: _________________ State: ____ Zip: ________

Billing/Mailing Address: _______________________ City: _________________ State: ____ Zip: ________
O Same as home address

Preferred Phone Contact: _______________________
O Home O Work O Cell
May we leave a confidential message at this number? O Yes O No

Alternate Phone Contact: _________________________
O Home O Work O Cell
May we leave a confidential message at this number? O Yes O No

Email Address: ____

Initial here if you are directing us to email you through unencrypted, non-siloed, general web-based email: _____

Emergency Contact #1

Name: _______________________Phone:__________

Relationship to Member: _______________________

Emergency Contact #2 (optional)

Name: _____________________ Phone:__________

Relationship to Member: ______________________