

**Family Physicians**

DAVID B. FARLEY, MD  
 JOYCE S. ENDO, MD  
 RYAN G. SCOTT, MD

**WEST LINN FAMILY HEALTH CENTER, PC**

18380 Willamette Dr., Suite 202  
 West Linn, Oregon 97068  
 ph 503.635.8384  
 fax 503.636.6475

[www.WestLinnFamilyHealthCenter.com](http://www.WestLinnFamilyHealthCenter.com)

**Family Nurse Practitioners**

CHERIE MARTCHENKE, FNP  
 LIBERTY C. FORT, PA  
 LINDA CIOFFI, FNP  
 RYAN CATE, PA  
 CAROLYN GARNETT, PA

PATIENT INFORMATION					
PATIENT NAME – LAST	FIRST	INITIAL	PREFERRED FIRST NAME (IF DIFFERENT)	SEX	MARITAL STATUS
PRESENT ADDRESS			CITY	STATE	ZIP
BIRTHDATE	AGE	SOCIAL SECURITY NUMBER		HOME PHONE	
EMPLOYER			OCCUPATION	WORK PHONE	
				CELL PHONE	
RELIGION	REFERRED BY		TODAY'S DATE	HAVE ANY HOUSEHOLD FAMILY MEMBERS BEEN SEEN HERE BEFORE?	

SPOUSE ~OR~ PARENT(S) INFORMATION					
SPOUSE'S NAME <i>(if applicable)</i>		FATHER'S NAME <i>(if applicable)</i>		MOTHER'S NAME <i>(if applicable)</i>	
SPOUSE'S EMPLOYER <i>(if applicable)</i>	OCCUPATION	WORK PHONE	SOCIAL SECURITY NUMBER		
FATHER'S EMPLOYER <i>(if applicable)</i>	OCCUPATION	WORK PHONE	SOCIAL SECURITY NUMBER		
MOTHER'S EMPLOYER <i>(if applicable)</i>	OCCUPATION	WORK PHONE	SOCIAL SECURITY NUMBER		

IN CASE OF EMERGENCY		
NAME OF FRIEND OR RELATIVE <b>NOT LIVING WITH YOU</b> WHO WE COULD REACH IN CASE OF AN EMERGENCY		
NAME:	RELATION:	PHONE:

MEDICAL INSURANCE INFORMATION	
<i>(needs to be filled out even if a copy of the card was taken)</i>	
PRIMARY INSURANCE COMPANY	AMOUNT OF CO-PAY OR DEDUCTIBLE <i>(CIRCLE ONE)</i>
INSURANCE ADDRESS	
NAME OF PERSON WHO CARRIES THE INSURANCE	SOCIAL SECURITY #      DATE OF BIRTH <i>(mandatory)</i> RELATIONSHIP
INSURANCE ID #	INSURANCE GROUP #
SECONDARY INSURANCE COMPANY	AMOUNT OF CO-PAY OR DEDUCTIBLE <i>(CIRCLE ONE)</i>
INSURANCE ADDRESS	
NAME OF PERSON WHO CARRIES THE INSURANCE	SOCIAL SECURITY #      DATE OF BIRTH <i>(mandatory)</i> RELATIONSHIP
INSURANCE ID #	INSURANCE GROUP #