



Eric North, MD • Phoenix Senna North, MD
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www.hopefamilymedicineonline.com

Who would you like to see? Dr. Eric North Dr. Senna North

Date _____

Name _____ DOB _____

Address _____ Phone _____

Parent Name (if patient minor) _____ Parent DOB _____

How did you hear about us? (e.g. family member, friend). Please list name: _____

Ins. Co. _____ ID# _____

Do you have Medicare? Yes No Do you have Providence Choice? Yes No

Current primary care physician: _____

Medication List (no dosages necessary) _____

Comments: _____

I acknowledge this request terminates in 12 months if an appointment has not been made. Initials _____

Internal Office Only

- YES**, I will accept this person/family as new patient(s): Date _____ Initials _____
- NO**, I am unable to accept this person/family as new patient(s) at this time
- Chart made. Patient notified or LDM: Date _____ Initials _____ Appt Date and Time: _____
- New patient packet sent. Date _____ Initials _____
- Received medical records: Date _____ Initials _____
- Insurance assigned to HFM, if applicable. Date checked _____
- Verbally accepted by doctor