

Today's Date _____

Patient

Legal Name _____
Last First Middle
 Home Phone _____ Work Phone _____
 Address _____
Street or PO Box City State Zip
 Date of Birth _____ Social Security # _____
 Marital Status _____ Sex _____
 Employer _____ Occupation _____
 Have you ever received medical treatment under another name? Yes _____ No _____
 If yes, under what name? _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Spouse

Legal Name _____
Last First Middle
 Home Phone _____ Work Phone _____
 Address _____
Street or PO Box City State Zip
 Date of Birth _____ Social Security # _____
 Employer _____ Occupation _____

Insurance Information *(Please check those which apply)*

I have-
 Medicare _____ Oregon Health Plan _____ Health Insurance _____ No Insurance _____
 Medicare Number _____
 Oregon Health Plan Type *(as listed in the right-hand column of your card)* _____

Primary Health Insurance

Company _____
 Policy # _____ Group # _____
 Insured Name _____ DOB _____ Sex _____
 Employer _____ Relationship to Patient _____

I am receiving medical treatment as a result of an accident: Yes _____ No _____
 If yes, what type of accident? Motor Vehicle _____ Work Accident _____ Other _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted. This is for myself and/or dependents under 18. In addition, this signature will bind me as though the undersigned had personally signed the particular claim.

 Patient Signature Date