

**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