The Orthopedic and Sports Medicine Center of Oregon LLC, 1515 NW 18th Ave., Suite 300 Portland, Or. 97209

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit.

Referring Physician ____ phone #___________________________
Address ____
Primary Care Physician____ phone#____________________________
Address ____

A. Patient Name as it appears on your insurance card.

First_______________________ Last _______________________Middle________ Marital Status ________________
Birth date ____/____/___ Gender _______________ Social Security #_______-___-_______

Home Address ____ ________________________ _____ _______________
Street City State Zip Code
Home Phone (____) ______-________ Cell Phone (____) ______-_________ Other Phone (____) _____-_______
Is it ok to leave a message? ___________
Employer ____ Occupation_______________________________________

Employer Address ____ ____ ______ Work Phone (____) ______-_______
Street City State Zip Code

B. If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party __________________________________ Address __________________________________

Relationship to patient ______________________ Social Security # ______-_____-_______ Birth date _____/_____/_____

Employer ______________________________ Address_________________________ Work Phone (____) ______-_______

C. In case of EMERGENCY:

Person to contact ____________________________________relationship_____________ Phone (____) ______-_______

D. How do you intend to pay? Cash ___ Check ___Credit Card ___Insurance ___Medicare ___ Welfare ___ other ___

Motor Vehicle Ins Co.___________________________________ Mailing Address for Claims ___________________________
____
Phone (____)__________________________ Adjuster name____
Claim #____

Health Insurance Co. ___________________________ Address ____
Phone (____) ______-_______ Policy/ID # __________________________ Group # ______________________________
Subscriber Name ___________________________ Social Security # ______-___-_______ Birth date ___________________
Employer ____________________ Address __________________________________ Work Phone (____) ______-________

E. Reason for this visit: Height_____________ Weight____________

Date of Injury or onset of problem ___/___/___ Body Part____
Accident Details ____

F. Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

Signature ____ Date ____________________________