

REGISTRATION & PATIENT INFORMATION

Date: _____ Primary Care Physician: _____ Phone: _____

Patient Information (Please print clearly)

Name: _____ Male Female
Last First MI

Home Address: _____
Street / Apartment City State Zip

Phones: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Birthdate: _____ / _____ / _____ Age: _____ Married: Yes No Student: Yes No

SSN: _____ - _____ - _____ Driver's License #: _____

Employer's Name: _____

Employer's Address: _____
Street / Box City State Zip

Provide the following information about your *spouse, parent, or other person responsible* for health care payments.

Name of insured individual and/or person responsible for payment: _____

Relationship of the responsible person to the patient: _____ Birthdate: _____ / _____ / _____

Home Address: _____
Street / Apartment City State Zip

SSN: _____ - _____ - _____ Driver's License #: _____ Phone: (_____) _____

Current Employer: _____ Phone: (_____) _____

Employer's Address: _____
Street / Box City State Zip

Insurance Information

Primary Insurance Company: _____ Phone: (_____) _____

Name of Policy Holder: _____ Relationship: _____

SSN: _____ - _____ - _____ Driver's License #: _____ Phone: (_____) _____

Policy Holder's Address: _____
Street / Apartment City State Zip

ID #: _____ Group Number: _____ Effective Date: _____

Secondary Insurance Company: _____ Phone: (_____) _____

Name of Policy Holder: _____ Relationship: _____

SSN: _____ - _____ - _____ Driver's License #: _____ Phone: (_____) _____

Policy Holder's Address: _____
Street / Apartment City State Zip

ID #: _____ Group Number: _____ Effective Date: _____

Person to Contact in Case of Emergency: _____ Phone: (_____) _____

Relationship: _____ Alt. Phone: (_____) _____

NOTE:

If you are being seen for a Work Injury or Motor Vehicle Accident please fill out the proper section below, if neither applies please skip this section. Thank you.

Work Injury Information

Employer's Workers Compensation Carrier: _____

Address for Claims: _____
Street / Box City State Zip

Claim #: _____ Date of Injury: _____

Claim Adjuster's Name: _____ Phone: (_____) _____

Is claim currently in an open status: Yes No

Employer at time of injury: _____ Phone: (_____) _____

Have you –

Filed a written report with your employer (FORM 801) Yes No

Filed a report with any other Doctor or Hospital (FORM 827) Yes No

Attorney's Name: _____ Phone: (_____) _____

Motor Vehicle Accident Information

Patient was: Passenger Driver Pedestrian

Auto Insurance Company for the Patient: _____

Address for Claims: _____
Street / Box City State Zip

Claim Number: _____ Date of Accident: _____

Did accident occur in Oregon: Yes No If no, what state: _____

Claim Adjustor's Name: _____ Phone: (_____) _____

Insurance Agent's Name: _____ Phone: (_____) _____

Policy #: _____ Policy Holder's Name: _____

Policy Holder's Phone Number (_____) _____ Relationship to Patient: _____

Attorney's Name: _____ Phone: (_____) _____