



2329 Pacific Avenue, Forest Grove, OR 97116  
Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_  
          Last           First           M.I.

Date of Birth: \_\_\_\_\_ Sex: F M

Address:

\_\_\_\_\_ Street/ P.O. Box           City           State           Code           Zip

Phone: Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Emergency Contact:

\_\_\_\_\_ Name           Relation to patient           Telephone number

Occupation: \_\_\_\_\_ Children: Y N How many? \_\_\_\_\_

Marital Status: Single: \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Other \_\_\_\_\_

Do you live with: Spouse \_\_\_\_\_ Friends \_\_\_\_\_ Parents \_\_\_\_\_ Alone \_\_\_\_\_ Children \_\_\_\_\_

How did you hear about us?  
\_\_\_\_\_

Health care and preventive medicine are only possible when the Physician has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything that you don't understand with a question mark.

\_\_\_\_\_

When did you last go to a doctor's office, medical clinic, or hospital? What was the reason?  
\_\_\_\_\_  
\_\_\_\_\_

What are your most important health problems? List as many as you can in order of importance.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consent for Treatment

**Medical Consent:** My care as a patient is directed by a licensed supervising physician. I consent to services rendered and provided to me under the instruction of supervising staff physicians.

Consent for Release of Information

**Release of Information to Physician, Referring Physician, Insurers and Professional Review**

**Organization:** I authorize release of medical and related information, including alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment to the insured’s insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment or payment for services provided or to be provided. This information may be released via first class mail, facsimile or certified courier, as applicable. Authorization may be withdrawn at any time by written notification.

**Social Security numbers:** Forest Grove Health & Fitness collects administrative and nonmedical patient data including social security numbers for the purpose of patient identification, compliance with federal and state agency reporting requirements, billing to insurance carriers and collection needs. Disclosure of the social security number information is voluntary. I have provided this information to and authorize Forest Grove Health & Fitness to use this information for the purpose stated above.

Statement of Financial Responsibility.

**Financial Agreement:** The undersigned, jointly and severally, in consideration of services to be rendered to patient, agree to pay each provider of service, in accordance with their regular rates and terms, for the services rendered. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal. The undersigned assigns to each provider of service all insurance benefits available for their professional and clinic services rendered. The assignment is irrevocable, and the undersigned authorizes carrier of said benefits to make payment directly to Forest Grove Health & Fitness or other related billing services. Payments received from insurers will apply to the patient’s account balance obligation. The undersigned agrees to promptly pay any charges that are not immediately (within 30 days) covered by insurance. Forest Grove Health and Fitness and its practitioners cannot guarantee quoted benefits and/or payment from insurance on services received.

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I agree to the above consents, authorizations to release information, and financial agreement that apply to the medical services provided for two years from the date shown below.

I have read, fully understand, and agree to the above statements.

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Patient (18 years or older)

Date

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Parent, Guardian, Responsible Party, Legal Representative

Date

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Witness

Date