



2329 Pacific Avenue, Forest Grove, Oregon

Confidential Patient Information

503-357-1706

Patients Last name: _____ First Name: _____ MI: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Date Of Birth: _____ Sex: _____ E-mail: _____
How did you hear about us? _____ Minor Child: Y N

Patients Employer: _____ Phone: _____
Address: _____ City: _____
State: _____ Zip: _____
Job Title: _____ Job Status: Full Time Part time
Student Not Employed

Spouse's Last Name: _____ First Name: _____ MI: _____
Name Of Emergency Contact: _____ Phone: _____

Person legally responsible for account, if other than patient:
Insured's Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Relationship to patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Job Title: _____ Phone Number: _____
Family Physician: _____ Phone Number: _____

Is this visit a result of an auto accident? Yes ___ No ___ Date of accident: _____

Primary/Auto Insurance:
Card Number: _____ Policy Number: _____
Group Number: _____ Relationship to insured if different than patient: _____

Secondary Insurance Company:
Card Number: _____ Policy Number: _____
Group Number: _____ Relationship to Insured if different than patient: _____

I understand and agree that insurance payments are an arrangement between and insurance carrier and myself. I authorize the release of medical information to determine the benefits payable to insurance for related services. Furthermore, I understand that the doctor's office will prepare any necessary forms and reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor will be credited to my account upon my receipt. However, I clearly understand and agree that all services rendered me are charged to my account directly and I am responsible for payment. I also understand that if I suspend or terminate my treatments in this office, all fees for services rendered to me become due and payable immediately.

Signature of patient or responsible party

Date: