Patient Information Form

Personal Information:

Patient Name : F:_______________ M: _______________ L: _______________ Today's Date: ______________________

Social Security Number: _____________________ Marital Status M / D / W / S DOB: ________________ Sex: ______

Home Address: ____ City: __________________ State: _______ Zip:____________

Home Phone: ___________________ Work Phone: ____________________ Cell phone: ___________________

Emergency Contact Name: ________________________________ Relationship: ________________Phone No: ________________

Responsible Party (if other than self, or if patient is a minor):

Name:____ DOB:____________ SSN: _________________________

Mailing Address: _______________________________ City: __________________ State: _______ Zip:____________

Home Address: _________________________________ City: __________________ State: _______ Zip:____________

Referring Physician: _________________________________ Telephone Number: ____

Primary Care Physician: ______________________________ Telephone Number: ____

Insurance information

Is insurance in your name Y /N If no, who carries this insurance? ____________________________ Their DOB: ____________

Primary Ins: ____ Grp # _________________________ ID # ________________

Insurance Phone No: ____________________________________ Address: ____

Secondary Ins: ____ Grp # _________________________ ID # ________________

Insurance Phone No: _______________________ Address: ____

Workers Comp: ________ MVA: _______ Insurance: ____ Claim # _______________

DOI: ___________ Claims Representative: ____ Phone #: _________________

Accepted Condition for this Injury: ____

Authorization Required? ________ Authorization # ____

PLEASE READ, SIGN and Return this form to the receptionist

By signing this form I also authorize Oregon Anesthesiology Group, on behalf of my doctor, to bill my insurance and release any information necessary to secure payment of benefits. I acknowledge that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I the undersigned, agree to pay for all costs and expenses, including reasonable attorney fees.

Signature: ____ Date: _______________________

I hereby authorize assignment and payment of major medical benefits due to me to the Oregon Anesthesiology Group/Interventional Pain Consultants. A photocopy of this assignment is to be considered as valid as an original.

Signature: ____ Date: _______________________