Orthopedic Specialists, P.C.

5050 NE Hoyt Street, Suite 340
Portland, OR 97213

Date: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Last Name First Name MI

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ DP Age:_____

Address: _____ #: _____ City: _____ State: _____ Zip:_____

Phone #1: _____ Phone #2: _____ Phone #3: _____

May we leave a private message at any of the above numbers? YES/NO (please circle) If so which one(s)? 1, 2, 3

Email Address: _____ Occupation: _____

Employer: _____ Phone: _____

Referring Provider: _____ PCP: _____

GUARANTOR (if not patient)

Guarantor Name : _____ Date of Birth:_____

Address: _____ #: _____ City: _____ State: _____ Zip:_____

Phone #1: _____ Phone #2: _____ Phone #3: _____

May we leave a private message at any of the above numbers? YES/NO (please circle) If so which one(s)? 1, 2, 3

INSURANCE

Primary: _____
Phone: _____

Insured's Name: _____

Insured's DOB: _____ Relation to patient: _____

ID#: _____

Group #: _____ Employer: _____

Secondary: _____
Phone: _____

Insured's Name: _____

Insured's DOB: _____ Relation to patient: _____

ID#: _____

Group #: _____ Employer: _____

ACCIDENT INFORMATION

Was this an injury? ☐Yes ☐No Date of injury? _____ On the job ☐Yes ☐No Auto Accident ☐Yes ☐No

EMERGENCY CONTACT

Name: _____ Phone#: _____ Relationship: _____

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Race: Please Circle One	Ethnicity: Please Circle One
American Indian/ Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White Undetermined	Hispanic or Latino Not Hispanic or Latino Other or Undetermined

Language Spoken: _____

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize Orthopedic Specialists, PC, physicians and staff, to release any medical information to my primary care physician, referring physician and to my insurance companies acquired during the course of my orthopedic exam and treatment.

_____ _____
Patient or Parent Signature Date

AUTHORIZATION FOR INSURANCE COMPANY TO PAY

I hereby request and authorize that my insurance company pay benefits directly to Orthopedic Specialists, PC for the medical and surgical services they provide to me. It is understood that charges for these services are submitted at usual and customary rates.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for any and all charges not covered by my insurance company. Co-pays, deductibles and all non-covered services are my responsibility. Co-pays are required to be paid at the time of service.

_____ _____
Patient or Parent Signature Date