ORTHOPEDIC SPECIALISTS, P.C.

5050 N.E. HOYT STREET – SUITE 340
PORTLAND, OREGON 97213

DATE ________________________ ACCOUNT #________________________

REFERRED BY DOCTOR ____

NAME OF PATIENT ________________________________ AGE ________ SEX ________

DATE OF BIRTH ________________________ EMAIL ________________________

PHONE # ________________________ CELL PHONE #________________________

ADDRESS ________________________ CITY ________________ STATE ______ ZIP ________

EMPLOYER ________________________________ OCCUPATION ________________

ADDRESS ________________________________ PHONE # ________________

MARITAL STATUS S ❑ M ❑ W ❑ D ❑

SPOUSES NAME ________________________________ EMAIL ________________

SPOUSE'S DATE OF BIRTH ________________________________

EMPLOYER ________________________________ OCCUPATION ________________

ADDRESS ________________________________ PHONE # ________________

IF PATIENT IS A MINOR

(IF DIFFERENT THAN ABOVE)

FATHER'S NAME ________________________ DATE OF BIRTH ____________ EMAIL ____________

FATHER'S ADDRESS ________________________________ PHONE #________________

FATHER' S EMPLOYER ________________________________ PHONE #________________

(IF DIFFERENT THAN ABOVE)

MOTHER'S NAME ________________________ DATE OF BIRTH ____________ EMAIL ____________

MOTHER'S ADDRESS ________________________________ PHONE #________________

MOTHER'S EMPLOYER ________________________________ PHONE #________________

REASON FOR SEEING DR.

COMPLAINT ____

WAS IT AN INJURY? NO ❑ YES ❑ DATE ________________ ON THE JOB ❑ AUTO ACCIDENT ❑

EMPLOYER AT TIME OF INJURY________________________ OTHER ❑ ________________

INSURANCE

PRIMARY INSURANCE ________________________________ INSURED'S NAME________________

ID / CLAIM # ________________ GROUP # ________________ INSURED'S DATE OF BIRTH ____________

SECONDARY INSURANCE ____

MEDICARE #________________________________ WELFARE #________________

EMERGENCY CONTACT ________________________________ RELATIONSHIP________________

ADDRESS ________________________________ PHONE # ________________

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AUTHORIZATION TO RELEASE INFORMATION

I, ____ , hereby authorize Orthopedic Specialists, P.C., 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 examination 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, P.C., for the medical and surgical services they provide to me. It is understood that charges for these services are submitted at the 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 requested to be paid at the time of the visit.

____   ________________________

Responsible Party Signature   Date