ORTHOPEDIC & TMJ PHYSICAL THERAPY CENTER

9204 SE Mitchell St., Portland, OR 97266

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Patient's Legal name: ________________________________ Nickname: ___________ Today's date: __________

If minor, parent's name ____

Address: ____________________________________ City: ______________ State: _______ Zip: ____________

Phone #'s: Home ____________________ Cell ______________________ Work ________________________

Employer: _________________ Occupation: ________________________

Address: ________________________________ City: _______________ State: __________ Zip: ____________

Birthdate: __________ Age ___ Driver's license #: ____________ State ____ Social Security # _______________

Male___ Female___ Marital status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Significant other's name __________________________________

Referring Doctor Full Name: _______________________ Phone # ______________ FAX: ___________

Other Doctors (and phone numbers), involved in current care: ____

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Area(s) to be treated: ______________________________ Allergies or chemical sensitivities: _______________

Person to contact in case of emergency: _____________________________ Relationship: __________________

Address: ____________________________ City: ________________ State: __________ ZIP: ____________

Home Phone # _______________ Cell: ____________ Work Phone: ___________________

HEALTH INSURANCE INFORMATION: **Check if None ________**

Primary insurance: ___________________ Type of Plan: ____________ Phone# _________________________

Address: ________________________________ City: _________________ State: ___________ Zip: ___________

Insured's name as it appears on card: ____________________ Group # ___________ ID# _____________________

Relationship to Insured: Self ___ Spouse ___ Child ___ Other __________________

Secondary insurance: _________________ Type of Plan: _______________ Phone# _______________________

Ins. Co. Address: __________________________ City: _________________ State: __________ Zip: ___________

Insured's name as it appears on card: ___________________ Group #: ___________ ID# _____________________

Relationship to insured: Self ___ Spouse ___ Child ___ Other __________________

(If other than patient) DOB: __________ Home Phone # ________________ Cell# ________ Work # __________

Insured's Address: _______________________________ City: __________________ State: ______ Zip: ________

Employer: _______________________________ Employer's Phone # _____________________

Attorney's name (if applicable): ___________________________ Phone: _______________ FAX: _____________

Address: _______________________________________ City: _____________ State: ________ Zip: ___________

I found you initially by: Doctor referral _____ Friend (name) _______________________________

Yellow page ad _____ Internet ________ Other ______________________

If I am unable to keep my appointment, I will give at least 24 hours notice. Otherwise, I understand I may be charged for the appointed time reserved for me. My insurance will not pay this broken appointment charge.

I authorize the release of medical or other information necessary to process insurance claims. I request payment of government benefits to the party who accepts assignment on the billing form. I also authorize payment of medical benefits to the undersigned physician or supplier for services described on the billing form.

Patient or Authorized Signature: ____ Date: ________________