
ORTHOPEDIC & TMJ PHYSICAL THERAPY CENTER, 9204 SE Mitchell St., Portland, OR 97266

Patient's name: _____ Today's date: _____

If minor, parent's name _____

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

Phone #'s: Home _____ Cell _____ Work _____

Employed by: _____ Occupation: _____

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

Birthdate: _____ Age: _____ Driver's license #: _____ Social Security # _____

Male ___ Female ___ Marital status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Significant other's name _____

Referring Doctor: _____ Phone # _____

Other Doctors, and phone numbers, involved in current care: _____

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

Person to contact in case of emergency: _____ Relationship: _____

Phone # _____

WORKERS COMPENSATION CLAIMS

Name of Insurance Carrier: _____ Date of Accident: _____

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

Adjuster: _____ Phone # _____

Employer at Time of Injury: _____ Claim #: _____ Policy# _____

Health Insurance: _____ Phone #: _____

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

Insured's name _____ Group #: _____ ID # _____

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

If applicable, Attorney's Name: _____ Phone: _____

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

I found you initially by: Doctor Referral ___ Friend(Name) _____
Yellow Page Ad ___ Other _____
Internet _____

If you are unable to keep your appointment, kindly give us 24 hours notice. Otherwise, a charge may be made for time reserved. Your insurance will not pay this charge.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or 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:** _____