ORTHOPEDIC & TMJ PHYSICAL THERAPY CENTER

9204 SE Mitchell St., Portland, OR 97266 Phone: (503) 777-6746

PATIENT INFORMATION:

Patient's Legal name: _____Nickname: _____Today's date: _____

If minor, parent's name _____

Address: _____City: _____State: _____Zip: _____

Phone #'s: Home _____ Cell _____Work _____

Employed: Y N Full or Part Time Employer: _____Occupation: _____

Address: _____City: _____State: _____ Zip: _____

Email address:_____ **Reminder Preference:Email, text, phone call**

Birthdate: _____Age ___Driver's license #: _____State ____

Male___ Female___

Marital status: Single ___Married ___Separated ___Divorced ___Widowed ___

Significant other's name_____

Referring Doctor Full Name: _____Phone #_____FAX: _____

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

Emergency Contact: _____Relationship: _____

Home Phone #_____Cell: _____Work Phone:_____

HEALTH INSURANCE INFORMATION:

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 _____

Person Responsible for Paying Account (If other than patient)

Name:_____ DOB: _____ Home Phone # _____Cell#_____ Work _____

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)_____

Internet (website)_____ 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: _____