PORTLAND SURGEONS - Patient Registration

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: M F

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

Home phone #: _____ Mobile phone #: _____

Email Address: _____ Social Security Number: _____

Employer/Occupation: _____ Work Phone #: _____

Marital status: (Married, Divorced, Single, Separated, Other) Ethnicity: (Hispanic, Non-Hispanic, Unknown)

Race: (African American, Asian, Caucasian, Native American, Hawaiian, Pacific Islander, Other, Unknown)

Preferred Language: _____

Primary Physician (PCP): _____ Office Phone: _____

Who referred you? _____ Telephone: _____

Emergency contact/**Relationship**: _____ Telephone: _____

Preferred Pharmacy: _____ Telephone: _____

Pharmacy Address: _____

_____

Responsible Party for Payment (**Must be filled out if patient is less than 18 years of age**.)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Telephone (Home): _____ Telephone (Other): _____

Primary Insurance

Insurance Name: _____ Copay: $_____

Policy Holder/Subscriber Name: _____ Relationship: _____

Ins. Address: _____ City: _____ State: ____ Zip Code: _____

ID No. or Social Security No.: _____ Group or Plan No.: _____

Subscriber date of birth: _____

Secondary Insurance

Insurance Name: _____ Co-pmt $: _____

Policy Holder/Subscriber Name: _____ Relationship: _____

Ins. Address: _____ City: _____ State: ____ Zip Code: _____

ID No. or Social Security No.: _____ Group or Plan No.: _____

Subscriber date of birth: _____