PORTLAND SURGEONS - Patient Registration

Date: _____

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

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

Home phone #: _____ Mobile phone #: _____

Emergency contact: _____ Telephone: _____

Relationship to contact: Spouse, Child, Grandparent, Parent, Grandchild, Sibling, Neighbor, Roommate, Friend, Partner, Other

Email address: _____ Social security number: _____

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

Race: African American, Asian, Caucasian, American Indian, Hawaiian, Pacific Islander, Unknown, Decline

Preferred Language: _____

Who referred you? _____ Telephone: _____

Primary Physician (PCP): _____ Office Phone: _____

Preferred Pharmacy: _____ Telephone: _____

Pharmacy Address: _____

Employer/Occupation: _____ Work Phone #: _____

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: $_____

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

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

Policy Holder/Subscriber Name: _____ Relationship: _____

Subscriber date of birth: _____

Secondary Insurance

Insurance Name: _____ Co-pmt $: _____

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

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

Policy Holder/Subscriber Name: _____ Relationship: _____

Subscriber date of birth: _____