PATIENT INFORMATION

NAME - LAST	FIRST	MIDDLE	DATE OF BIRTH	GENDER	MARITAL STATUS:
				M F	SINGLE MAR DIV SEP WID

ADDRESS	CITY	STATE	ZIP

PHONE NUMBER	CELL PHONE	LEAVE MESSAGE:	OK TO TEXT:	INDICATE PREFERRED METHOD OF CONTACT:
		YES NO	YES NO	HOME CELL OTHER

EMAIL		

Hispanic or Latino: Y N	Ethnicity:	Language:

SPOUSE:	PHONE NUMBER	

PHARMACY	PHONE NUMBER:	

Referring Physician:		Phone:

Primary Care Physician:		Phone:

EMPLOYER	OCCUPATION		

Address	CITY	STATE	ZIP

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE (Not living at the same address):	**RELATIONSHIP TO PATIENT:**	**PHONE:**

INSURANCE INFORMATION

PRIMARY INSURANCE	ID NUMBER	GROUP NUMBER	

INSURANCE ADDRESS	CITY/STATE	ZIP	PHONE NUMBER

SUBSCRIBER NAME - LAST	FIRST	MIDDLE	DATE OF BIRTH	GENDER	RELATIONSHIP TO PATIENT
				M F	

SECONDARY INSURANCE

SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER	

INSURANCE ADDRESS	CITY/STATE	ZIP	PHONE NUMBER

SUBSCRIBER NAME - LAST	FIRST	MIDDLE	DATE OF BIRTH	GENDER	RELATIONSHIP TO PATIENT
				M F	

MOTOR VEHICLE ACCIDENT / WORKERS COMPENSATION

DATE OF ACCIDENT/INJURY:	CLAIM NUMBER:	ADJUSTERS NAME AND PHONE NUMBER:

INSURANCE CARRIER	PHONE

INSURANCE ADDRESS	CITY	STATE	ZIP

EMPLOYER	OCCUPATION:		

ADDRESS	CITY	STATE	ZIP

ATTORNEY NAME	PHONE NUMBER	FAX NUMBER

ADDRESS	CITY	STATE	ZIP

The above information is true to the best of my knowledge. I understand that I am financially reponsible for any balance not covered by insurance carrier.

MEDICARE - I request that my payment of authorized medical benefits be made on my behalf to Oregon Spine Care LLC and/or Robert L.Tatsumi MD PC, for any services rendered to me. I hereby authorize permission to release to the healthcare administrator and its agents any medical information needed to determine these benefits payable for related services under Title XVII of the Social Security Act.

COMMERCIAL - I hereby authorize the release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME to Oregon Spine Care LLC and/or Robert L. Tatsumi MD PC.

Patient/Guardian Signature:_____ **Date:** _____