## 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:** _____