DATE ___/___/___

OREGON PLASTIC SURGEONS

REFERRED BY

PRIMARY CARE PHYSICIAN

PATIENT INFORMATION

GENERAL INFORMATION

PATIENT'S FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE ___/___/___
PATIENT'S ADDRESS (IF MAILING ADDRESS IS PO BOX, STREET ADDRESS REQUIRED ALSO)			SEX M F / AGE / ❑S ❑D ❑DP ❑M ❑W
CITY	STATE		ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	
PREFERRED DAYTIME NUMBER (CIRCLE ONE) HOME CELL WORK	Oregon Drivers License #	PATIENT'S SOCIAL SECURITY NUMBER	
PATIENT'S EMPLOYER	OCCUPATION	PATIENT'S EMAIL ADDRESS OK TO CONTACT WITH PROMOTIONS? ☐ YES ☐ NO	

SPOUSE, GUARDIAN OR RESPONSIBLE PARTY INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE ___/___/___	RELATIONSHIP TO PATIENT
EMPLOYER			SPOUSE'S SOCIAL SECURITY NUMBER	
HOME PHONE NUMBER	CELL PHONE NUMBER		WORK PHONE NUMBER	

NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU (ALTERNATE CONTACT REQUIRED)

NAME	RELATIONSHIP	PHONE NUMBER

INSURANCE

PRIMARY HEALTH INSURANCE

INSURANCE CO.			SUBSCRIBER
CLAIM BILLING ADDRESS			EMPLOYER
INSURANCE PHONE NUMBER	GROUP #	I.D. #	PRE-AUTH REQUIRED ☐ YES ☐ NO

SECONDARY HEALTH INSURANCE

INSURANCE CO.			SUBSCRIBER
CLAIM BILLING ADDRESS			EMPLOYER
INSURANCE PHONE NUMBER	GROUP #	I.D. #	

ACCIDENT

COMPLETE SECTION BELOW IF THIS IS AN ON-THE-JOB INJURY, AUTOMOBILE, OR HOUSEHOLD ACCIDENT		INS. CARRIER
HOW DID INJURY OCCUR?		CLAIM NUMBER
DATE OF INJURY	IF UNABLE TO WORK, DATE LAST WORKED	ADJUSTER'S NAME
WHERE DID INJURY OCCUR? ❑ AT WORK ❑ AT HOME ❑ OTHER: EXPLAIN		ADJUSTER'S PHONE NUMBER
PREVIOUS DOCTORS SEEN FOR THIS INJURY		CLAIMS ADDRESS

Assignment and release: I hereby assign my insurance benefits to be paid directly to my treating physician. I understand that I am financially responsible for non-covered services. I authorize my treating physician to release any information required to process this claim. I consent to medical photography and authorize release for medically related purposes.

Signed _____ Date _____

Thank you for choosing our office!