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!***