Eastside Orthopedics & Sports Medicine, 6542 SE Lake Rd., Suite 201 Milwaukie, OR 97222

PATIENT REGISTRATION FORM

Completion of this information in its entirety is required at the time of visit

PATIENT INFORMATION

First:_____Last_____MI:_____Preferred Name_____

Birth Date ___/___/____Age____ Gender_____ Marital Status_____Social Security#_____

Mailing Address_____
Street City State Zip Code

Home Phone(____)_____-_____ Cell Phone (____)_____-_____ Work (____)_____-_____

May we leave a message on all numbers? Yes No Preferred Number:_____

Employer_____ Occupation_____

I have read and understood the Notice of Privacy Practices(see website) or you may request a copy ☐Yes☐ No

I have read and understood the Patient Financial Policy (see website) or you may request a copy ☐ Yes ☐ No

I authorize the following to receive my medical information: ☐ Spouse ☐ Primary Care Physician

Other:_____

Below is required by Federal Statistics and Administration reporting for medical research purposes

Race: ☐ I decline to answer ☐ American Indian or Alaska Native ☐Asian
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Black or African American

Ethnicity: ☐ I decline to answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language Preference: _____ Email Adress:_____

GUARANTOR (if patient is under 18 years of age):

Name_____Address_____

City_____ State_____ Zip_____ Social Security #_____Birth Date ___/___/____

Relationship to patient_____ Employer_____ Work Phone (___)____-_____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone(___)____-_____

PRIMARY INSURANCE INFORMATION

Insurance Company_____ Address_____

Phone (____)____-_____ Policy/ID #_____ Group #_____

Subscriber Name_____Social Security #_____ Birth Date___/___/_____

Effective Date_____ Copay _____

Does your insurance require a referral? ☐ Yes ☐ No

SECONDARY INSURANCE INFORMATION

Insurance Company_____ Address_____

Phone (____)____-_____ Policy/ID #_____ Group #_____

Subscriber Name_____Social Security #_____ Birth Date___/___/_____

Effective Date_____ Copay _____

ACCIDENT/INJURY INFORMATION

Date of injury or onset of symptoms? _____**Did this injury occur at work?**☐Yes ☐No **Auto Accident?** ☐Yes ☐No

What happened?

Assignment of Benefits: I herby authorize the release of any medical information necessary to process insurance claims. I authorize direct payment to Bret T. Kean, MD, Paul D. Ruesch, MD, Matthew T. Sugalski, MD and Eastside Orthopedics & Sports Medicine.

Signature: **Date:**