NORTHWEST BRAIN & SPINE

2275 NE Doctors Drive • Bend, OR 97701 • 541-585-2400

PATIENT INFORMATION

Do you have medical insurance? YES ☐ NO ☐

Last: _____ First: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Marital Status: ☐ M ☐ W ☐ S ☐ D ☐ OTHER Gender: ☐ Male ☐ Female Ht: _____ Wt: _____

Social Security #: _____ Primary Care Physician: _____

Employer Name: _____ Employer Phone: (___) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: (___) _____ Relationship: _____

RESPONSIBLY PARTY INFORMATION

(IF PATIENT IS A MINOR OR IF POWER OF ATTORNEY IS INVOLVED)

Last: _____ First: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Marital Status: ☐ M ☐ W ☐ S ☐ D ☐ OTHER Gender: ☐ Male ☐ Female

Social Security Number: _____ Relationship to Patient: _____

Employer Name: _____ Employer Phone: (___) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

IF YOU ARE NOT THE SUBSCRIBER ON THE INSURANCE CARD, PLEASE FILL OUT THE FOLLOWING:

Insurance Company Name: _____ Social Security Number: _____

Subscriber Last Name: _____ First Name: _____ Middle: _____

Subscriber Phone: ( ) _____ Subscriber Birth Date: _____ Gender: _____

Policy #: _____ Group #: _____

Authorization to release information ***Assignment of Insurance Benefits*** agreement/contract

I authorize NW Brain & Spine to release information acquired during course of treatment to my insurance carriers.

I authorize NW Brain & Spine to provide care for myself, minors and any others covered under this account. I accept full responsibility for payment thereof, and I hereby assign NW Brain & Spine any all-insurance benefits due me to the full extent of my financial obligation to said provider.

I understand my insurance coverage is a relationship between my insurance company and myself and agree to accept financial responsibility for charges incurred. I understand that I may be billed for un-cancelled appointments. In the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Patient or Responsible Party Signature _____ Date _____