The Orthopedic and Sports Medicine Center of Oregon LLC, 1515 NW 18th Ave., Suite 300 Portland, Or. 97209

WORKERS COMPENSATION PATIENT REGISTRATION FORM
Completion of this information in its entirety is required at time of visit.

Primary Care Physician _____ phone #_____
Address _____
Who Referred you to us_____ phone#_____
Address _____

A. Patients legal name.
First_____ Last _____Middle_____ Preferred Name _____
Birth date ____/____/___ Gender _____ Marital Status _____ Social Security #_____-___-_____
Mailing Address _____ _____ _____ _____
Street City State Zip Code
Home Phone (____) _____-_____ Cell Phone (____) _____-_____ Work Phone (____) _____-_____

Is it ok to leave a message? _____E Mail Address_____

Employer _____ Occupation_____

Employer Address _____ _____ ____ _____ Phone (____) _____-_____
Street City State Zip Code

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

Name _____ Address _____
City_____ State____ Zip_____ Social Security # _____-_____-_____ Birth date _____/_____/_____
Relationship to patient _____ Employer _____ Work Phone (____) _____-_____

C. In case of EMERGENCY:

Person to contact _____relationship_____ Phone (____) _____-_____

D. How do you intend to pay?
PLEASE NOTE THAT WE DO NOT AWAIT SETTLEMENT PROCEEDINGS FOR PAYMENT

Workers' Compensation insurer's name_____Address_____

Date of injury____/____/_____ **Claim #**_____Phone(____)_____

Employer at time of injury _____

Address_____ Work Phone (_____)_____

Health Insurance Co. _____ Address _____
Phone (____) _____-_____ Policy/ID # _____ Group # _____
Subscriber Name Social Security # - - Birth date

E. Reason for this visit: Height_____ Weight_____

Date of Injury or onset of problem ___/___/___ Body Part_____
Accident Details _____

F. Please sign and return to the receptionist.
I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.
Signature _____ Date _____