

NW Rheumatology Associates, P.C.

New Patient

Update Only

Which physician will you be seeing _____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____
Address _____
Address _____
City _____ State _____ Zip _____
Phone _____ Home Work Other
Phone _____ Home Work Other

Patient ID# _____ Male Female
Date of Birth _____
Social Security # _____
Marital Status: Married Single
Employer _____

Referring Physician _____ Address _____ Phone _____
Primary Physician _____ Address _____ Phone _____

IN CASE OF EMERGENCY NOTIFY

Last Name _____ First _____
Address _____ Phone _____ Relationship _____

RESPONSIBLE PARTY INFORMATION: DO NOT COMPLETE IF RESPONSIBLE PARTY IS PATIENT

Last Name _____ First _____ Middle _____ Date of Birth _____
Address _____ Social Security # _____
City _____ State _____ Zip _____ Employer _____
 Same as Patient Phone _____ Phone 2 _____

REASON FOR VISIT

Illness Injury Job Related Injury Auto Accident Other

Only applicable if injury is related to work or auto accident

Claim Number _____ Date of Injury _____ Employer/Agency Phone _____ Employer at time of injury _____

PRIMARY INSURANCE INFORMATION

Same as Patient Same as Guarantor Other
Insurance Company _____
Insured Party Name _____
Insured Phone _____
Insured's Employer _____
Relationship to Insured _____
Social Security # _____
Insured ID _____
Policy Group _____
Insured's Date of Birth _____

SECONDARY INSURANCE INFORMATION

Same as Patient Same as Guarantor Other
Insurance Company _____
Insured Party Name _____
Insured Phone _____
Relationship to Insured _____
Social Security # _____
Insured ID _____
Policy Group _____
Insured's Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF INSURANCE BENEFITS/AGREEMENT/CONTRACT

I hereby authorize this clinic to release to the insurance company named above any information acquired in the course of my examination of treatment. If patient is minor, patient or guardian sign. I hereby authorize the clinic to leave medical information on my answering machine or with another adult at my residence. I hereby assign to this clinic any and all insurance benefits due me to the full extent of my financial obligation to this clinic. I understand my insurance coverage is a relationship between my insurance company and myself and I agree to accept financial responsibility for payment for charges incurred. I understand a finance charge of 5.99% per month may be applied to a balance more than 60 days old. In the event of non-payment, I will bear the cost of all collection and reasonable legal fees. Accounts assigned to collection will be charged a \$50.00 collection fee. As needed, I authorize NWRA to file a complaint with the Oregon Insurance Commissioner on my behalf.

Signature _____

Date _____