PATIENT INFORMATION					
NAME - LAST	FIRST	MIDDLE	DATE OF BIRTH	GENDER M F	MARITAL STATUS: SINGLE MAR DIV SEP WID
ADDRESS		CITY		STATE	ZIP
PHONE NUMBER	CELL PHONE	LEAVE MESSAGE: YES NO	OK TO TEXT: YES NO	INDICATE PREFERRED METHOD OF CONTACT: HOME CELL OTHER	
Language:			Ethnicity:		
Hispanic or Latino: Y N					
SPOUSE:		PHONE NUMBER		EMAIL	
PHARMACY		PHONE NUMBER:			
Referring Physician:				Phone:	
Primary Care Physician:				Phone:	
				M F	
ADDRESS		CITY		STATE	ZIP
EMPLOYER			OCCUPATION:		

IN CASE OF EMERGENCY		
NAME OF LOCAL FRIEND OR RELATIVE (Not living at the same address):	**RELATIONSHIP TO PATIENT:**	**PHONE:**

INSURANCE INFORMATION					
PRIMARY INSURANCE		ID NUMBER		GROUP NUMBER	
INSURANCE ADDRESS		CITY/STATE		ZIP	PHONE NUMBER
SUBSCRIBER NAME - LAST	FIRST	MIDDLE	DATE OF BIRTH	GENDER M F	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE					
SECONDARY INSURANCE		ID NUMBER		GROUP NUMBER	
INSURANCE ADDRESS		CITY/STATE		ZIP	PHONE NUMBER
SUBSCRIBER NAME - LAST	FIRST	MIDDLE	DATE OF BIRTH	GENDER M F	RELATIONSHIP TO PATIENT

MOTOR VEHICLE ACCIDENT / WORKERS COMPENSATION					
DATE OF ACCIDENT/INJURY:	CLAIM NUMBER:		ADJUSTERS NAME AND PHONE NUMBER:		
INSURANCE CARRIER				PHONE	
INSURANCE ADDRESS		CITY		STATE	ZIP
EMPLOYER			OCCUPATION:		
ADDRESS		CITY		STATE	ZIP
ATTORNEY NAME			PHONE NUMBER		FAX NUMBER
ADDRESS		CITY		STATE	ZIP

The above information is true to the best of my knowledge. I understand that I am financially reponsible for any balance not covered by insurance carrier.

MEDICARE - I request that my payment of authorized medical benefits be made on my behalf to Oregon Spine Care LLC and/or Robert L.Tatsumi MD PC, for any services rendered to me. I hereby authorize permission to release to the healthcare administrator and its agents any medical information needed to determine these benefits payable for related services under Title XVII of the Social Security Act.

COMMERCIAL - I hereby authorize the release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME to Oregon Spine Care LLC and/or Robert L. Tatsumi MD PC.

Patient/Guardian Signature:____ **Date:** __________________________