PLEASE PRINT

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| DATE:       | PRIMARY PHYSICIAN:       |
|  **PATIENT INFORMATION**  |
| Name (Legal) : Last First            | Marital Status: (Check one)[ ] Single [ ] Mar[ ] Div [ ] Sep [ ] Wid |
| Birthdate:       |  Age:       | Sex: [ ] Male [ ] Female  |
| Street Address:      | City:       | State:      | Zip Code:      |
| Occupation:       | Employer:       | Employer Phone Number:(     )      -       |
| How you were referred to this office?       |

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|  **INSURANCE INFORMATION**  |
| (Please give your insurance card to the receptionist) |
| Person responsible for bill:       | Birth Date:       |
| Address: (if different)Street:      | City:      | State:      | Zip:      |
| Name of Insurance Company:       |
| Subscriber policy number:       | Group number:       |
| Insurance phone number for Provider/Mental Health: (     )      -       |
| Patient’s relationship to subscriber: [ ]  Self [ ]  Spouse [ ]  Child/dependent [ ] Other:       |

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|  **IN CASE OF EMERGENCY**  |
| Name of local friend or relative:        | Phone: (     )      -       |

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|  **RELEASE TO BILL INSURANCE**  |
| The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to PDX Mental Health Resources, LLC. I understand that I am financially responsible for any balance. I also authorize PDX Mental Health Resources, LLC or insurance company to release any information to process my claims.

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| **Patient Signature:**       |

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