PLEASE PRINT

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DATE: | | PRIMARY PHYSICIAN: | | | |
| **PATIENT INFORMATION** | | | | | |
| Name (Legal) : Last First | | | | Marital Status: (Check one)  Single MarDiv 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? | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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: | | | |

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

|  |
| --- |
| **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.   |  | | --- | | **Patient Signature:** | |