EAST PORTLAND NEUROLOGY

Howard S. Taylor, M.D. * Vitalie D. Lupu, M.D. * Brent A. Burroughs, M.D.
Board Certified Physicians in Neurology

10101 S.E. Main St., Suite 1006, Portland, Oregon 97216 * 503-256-3034

MEDICARE PATIENT REGISTRATION FORM

Full Name _____ **Soc. Sec. #** _____
Last Name First Name Middle

Address _____ **Driver's License #** _____

City _____ **State** _____ **Zip** _____ **Home phone** _____ **Email** _____

Sex ☐ **M** ☐ **F** **Age** _____ **Birthdate** _____ ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Language _____ **Race** _____ **Ethnicity** _____

Patient Employer _____ **Work phone** _____

Referring Doctor _____ **Address** _____ **Phone** _____

Primary Care Physician _____ **Address** _____ **Phone** _____

PREFERRED PHARMACY:

Pharmacy Name _____ **Address** _____ **Phone** _____

PRIMARY HEALTH INSURANCE:

Insurance Co _____ **ID #** _____ **Group #** _____

Subscriber's Name _____ **Subscriber's Birthdate** _____ **Relationship to Patient** _____

Subscriber's Sex ☐ **M** ☐ **F** **Subscriber's Soc Sec #** _____ **Subscriber's Work Phone** _____

SECONDARY HEALTH INSURANCE:

Insurance Co _____ **ID #** _____ **Group #** _____

Subscriber's Name _____ **Subscriber's Birthdate** _____ **Relationship to Patient** _____

Subscriber's Sex ☐ **M** ☐ **F** **Subscriber's Soc Sec #** _____ **Subscriber's Work Phone** _____

Who is responsible for this bill? _____ **I will be paying today by cash:** _____ **check:** _____ **credit card:** _____

Are you currently employed? _____ **Is your spouse or other family member currently employed?** _____

Are you covered under an employer or union health plan? _____ **Did you sustain an injury while at work?** _____ **Are your injuries accident related?** _____

I hereby instruct and direct Medicare to pay by check made out and mailed to: East Portland Neurology, 10101 S.E. Main St., Suite 1006, Portland, Oregon 97216

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Authorizations period: from date noted below to lifetime.

Signature: _____ Date: _____