EAST PORTLAND NEUROLOGY

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PATIENT INFORMATION FORM

PATIENT INFORMATION *(Please print)*

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

Address _____ Email _____

City _____ State _____ Zip _____ Home phone _____

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

Language _____ Race _____ Ethnicity _____

Patient Employed by _____ Occupation _____

Employer's Address _____ Work phone _____

City _____ State _____ Zip _____ Driver's License # _____

Referring Doctor _____ Address _____ Phone _____

Primary Care Physician _____ Address _____ Phone _____

PREFERRED PHARMACY

Pharmacy Name _____ Address _____ Phone _____

PRIMARY HEALTH INSURANCE *(Please complete for all claims regardless of type of accident)*

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 *(Please complete for all claims regardless of type of accident)*

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 _____

I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

SIGNATURE: _____ DATE: _____