ORTHOPEDIC & TMJ PHYSICAL THERAPY CENTER
9204 SE Mitchell St., Portland, OR 97266 Phone: (503) 777-6746

PATIENT INFORMATION:

Legal name: ________________________________ Preferred Name: ___________ Today's date: __________
If minor, parent's name ____
Address: ______________________________ Apt: ___ City: ______________ State: OR / WA Zip: __________
Birthdate: _________ Legal Sex: Male ___ Female ___ Preferred pronouns (circle all that apply): He / She / They
Gender: Woman__ Man __ Non-binary __ Trans (M)___ Trans (F) __ Not listed: ________________

Reminder Preference (please circle): Email / text / phone call
Phone #'s: Home: ______________ Cell: ______________ Work: ______________
Email address:____

Emergency Contact: Name: _____________________________ Relationship: __________________
Home:_______________ Cell: _____________ Work Phone:_________________

I found you initially by: Doctor referral ____ Friend (Name) _______________ Ok to thank them? Y/N
Website _____ Other: __________________

Referring Doctor :
Name: _______________________ Phone :______________ FAX: ___________
Are you currently seeing another physical therapist? Yes ____ No _____

HEALTH INSURANCE INFORMATION:

Primary insurance:
Primary Subscriber Name: ____________________
Primary Subscriber Date of Birth:__________ Relationship to Subscriber: Self ___ Spouse ___ Child ___

Secondary insurance:
Primary Subscriber Name: ____________________
Primary Subscriber Date of Birth:__________ Relationship to Subscriber: Self ___ Spouse ___ Child ___

Person Responsible for Paying Account (If other than patient):
Name: __________________ Relationship: __________________
Home Phone: ____________ Cell:____________ Work:
If address is same as above check
Address: ________________________________ City: _________________ State: ______ Zip: ________

If I am unable to keep my appointment, I will give at least 24 hours notice. Otherwise, I understand I may be charged for the appointed time reserved for me. My insurance will not pay this broken appointment charge.

I authorize the release of medical or other information necessary to process insurance claims. I request payment of government benefits to the party who accepts assignment on the billing form. I also authorize payment of medical benefits to the undersigned physician or supplier for services described on the billing form.

Patient or Authorized Signature: ____ Date: ________________