PATIENT INFORMATION

Date: _____

oregon surgical specialists

PERSONAL INFORMATION		
Name:	**Birth Date:**	
Mailing Address:	**Gender:** M ☐ F ☐	
City:	**State:**	**Zip:**
Primary Phone:	**Secondary Phone:**	
Employer:	**Marital Status:** Single	
Work Phone:	**Preferred Language:**	
Primary Care Doctor:	**Ethnicity:**	
Referring Doctor:	**Email:**	
How did you hear about us?		

SPOUSE OR GUARDIAN INFORMATION	
Name:	**Relationship to patient:**
Employer:	**Birth date:**
Primary Phone:	**Secondary Phone:**
List as emergency contact? Y ☐ N ☐	

MEDICAL INSURANCE INFORMATION	
Insurance Co:	**Subscriber's Name:**
Please show card at check in	**Subscriber's Date of Birth:**
Patient's Relationship to subscriber:	
Secondary Medical Insurance Information	
Insurance Co:	**Subscriber's Name:**
Please show card at check in	**Subscriber's Date of Birth:**
Patient's Relationship to subscriber:	

ADDITONAL CONTACTS LIST: Please list people that you would allow our office to contact or release medical information to:

Name:	Primary number:	Alternate number:	Relation to you:
1.			
2.			
3.			