5200 S Macadam Avenue, Suite 200 | Portland, Oregon 97239
Phone # (503) 719-4208, Fax # (503) 719-4209
www.pacoregon.com

Patient Information

Name: ______________________ Date of Birth: ______________
Gender: Male Female Other Pronouns: ______________
Address: ______________________ Apt#: ________
City: ______________________ State: ________ Zip: ________
Primary Phone: ______________ (cell / work / home) Cell Phone Carrier: ______________
Secondary Phone: ______________ (cell / work / home)
Employer: ______________________ Occupation: ______________
Work Address: ______________________
Social Security #: ______________ Email Address: ______________
Primary Care Physician ______________________ Phone Number: ______________
Marital Status: Single Married Divorced Separated Widowed Partnered

Spouse Partner Parent Guardian Information (Check One)

Name of spouse, parent or guardian: ______________________
Street Address: ______________ Apt #: ______ City: ______________ State: ________ ZIP: ________
Mailing Address (if different): ______________________
Home Phone: ______________ Work Phone: ______________
Employer: ______________ Occupation: ______________
Work Address: ______________________
City/State/Zip ______________________ Date of Birth: ______________
Social Security #: ______________ Driver's License #: ______________

Insurance Holders' Information

Primary Insurance Co: ______________________ Phone #: ______________
Name of Insured: ______________________ Date of Birth: ______________
Home Phone: ______________ Work Phone: ______________
SS or ID #: ______________ Group #: ______________ Co-Pay Amount $ ________

Primary Insurance Co: ______________________ Phone #: ______________
Name of Insured: ______________________ Date of Birth: ______________
Home Address: ______________ Home Phone: ______________
SS or ID #: ______________ Group #: ______________

PLEASE PROVIDE YOUR INSURANCE CARD TO PHOTOCOPY

Other Important Information

Person to contact in an emergency (someone not living with you): ______________
Relationship to you: ______________________ Their phone #: ______________
How did you hear about our doctors? Phone Book Referred by Friend or Family Member
Referred by Physician: ______________ Previous Patient: ______________
Other (please specify): ______________________

I authorize Pacific Audiology Clinic or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the doctor. I understand that direct billing of insurance companies is done as a courtesy by Pacific Audiology Clinic, LLC and that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and acknowledges that their social security number may be used in collection efforts. I authorize Pacific Audiology Clinic to provide me with reasonable and proper medical care by today's standards.

Signature ______________________________ Date ______________