

OLSON PEDIATRIC CLINIC
16463 S.W. Boones Ferry Road
Lake Oswego, OR 97035
503-635-3743

ACCOUNT NO.

APPOINTMENT DATE:

PATIENT

NAME LAST FIRST MIDDLE SOC.SEC.NO.
ADDRESS SEX BIRTHDATE
CITY STATE ZIP HOME PHONE

FAMILY

STATUS OF PARENTS: if Other:

RESPONSIBLE PARTY NAME:

LAST FIRST MIDDLE DATE OF BIRTH SOC.SEC.NO.
ADDRESS EMPLOYER
CITY STATE ZIP PHONE HOME WORK

SPOUSE'S NAME:

LAST FIRST MIDDLE DATE OF BIRTH SOC.SEC.NO.
ADDRESS EMPLOYER
CITY STATE ZIP PHONE HOME WORK

BROTHER'S AND SISTERS NAMES (LAST, FIRST, MIDDLE):

BIRTHDATE SEX SOC.SEC.NO.
BIRTHDATE SEX SOC.SEC.NO.
BIRTHDATE SEX SOC.SEC.NO.
BIRTHDATE SEX SOC.SEC.NO.

EMERGENCY

PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN PARENTS: (Local: i.e. neighbor, friend, relative)

Name and Address

Relationship PHONE HOME WORK

AGREEMENT

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the attending physician all group or personal medical benefit or any other insurance benefits otherwise payable to me, to the extent of my medical bills.

Signed _____ Date

I hereby authorize the above Doctor/Doctors to furnish the insured's insurance company all information which said insurance company may request concerning my claim.

Signed _____ Date

Who referred you to this office?