Eastside Orthopedics & Sports Medicine

MILWAUKIE OFFICE: 6542 SE Lake Road, Suite 201, Milwaukie, OR 97222
GRESHAM OFFICE: 25050 SE Stark St, Suite 301, Gresham, OR 97030

PATIENT REGISTRATION FORM

Completion of this information in its entirety is required at the time of visit

PATIENT INFORMATION

First:_____Last_____MI:_____Preferred Name_____

Birth Date ___/___/____Age____ Gender_____ Marital Status_____Social Security#_____

Mailing Address_____
Street City State Zip Code

Home Phone(____)_____-_____ Cell Phone (____)_____-_____ Work (____)_____-_____

May we leave a message on all numbers? Yes No Preferred Number:_____

Employer_____ Occupation_____

I have read and understood the Notice of Privacy Practices(see website) or you may request a copy ☐Yes☐ No

I have read and understood the Patient Financial Policy (see website) or you may request a copy ☐ Yes ☐ No

I authorize the following to receive my medical information: ☐ Spouse ☐ Primary Care Physician

Other:_____

Below is required by Federal Statistics and Administration reporting for medical research purposes

Race: ☐ I decline to answer ☐ American Indian or Alaska Native ☐Asian
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Black or African American

Ethnicity: ☐ I decline to answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language Preference: _____ Email Adress:_____

GUARANTOR (if patient is under 18 years of age):

Name_____Address_____

City_____ State_____ Zip_____ Social Security #_____Birth Date ___/___/____

Relationship to patient_____ Employer_____ Work Phone (___)____-_____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone(___)____-_____

PRIMARY INSURANCE INFORMATION

Insurance Company_____ Address_____

Phone (____)____-_____ Policy/ID #_____ Group #_____

Subscriber Name_____Social Security #_____ Birth Date___/___/_____

Effective Date_____ Copay _____

Does your insurance require a referral? ☐ Yes ☐ No

SECONDARY INSURANCE INFORMATION

Insurance Company_____ Address_____

Phone (____)____-_____ Policy/ID #_____ Group #_____

Subscriber Name_____Social Security #_____ Birth Date___/___/_____

Effective Date_____ Copay _____

ACCIDENT/INJURY INFORMATION

Date of injury or onset of symptoms? _____**Did this injury occur at work?**☐Yes ☐No **Auto Accident?** ☐Yes ☐No

What happened?

Assignment of Benefits: I herby authorize the release of any medical information necessary to process insurance claims. I authorize direct payment to Bret T. Kean, MD, Paul D. Ruesch, MD, and Akash Gupta, MD

Signature: **Date:**