

# Rehabilitation Medicine Associates, P.C.

1040 NW 22<sup>nd</sup> Ave., Suite 320, Portland, OR 97210/19875 SW 65<sup>th</sup> Ave., Suite 250, Tualatin, OR 97062  
Portland and Tualatin Office Telephone 503-413-6294 – Fax 503-413-7780

**Please bring this completed form with you to your appointment.**

## Patient Information (Please Print):

\*Patient Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(First) (Middle Initial) (Last) (mm/dd/yy)

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License: \_\_\_\_\_  
(State) (Number)

Marital Status: Married  Single  Divorced  Spouse Full Name: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ May We Call You At Work? \_\_ Yes \_\_ No If Yes, Work Number: \_\_\_\_\_

*We do leave reminder calls and appointment related information at your home number. We have a service that leaves a recorded message either with a person or an answering machine. You must let our office know if you do not want calls made to your home. Remember: you are financially responsible for missed appointments. Thank you.*

Employer: \_\_\_\_\_ Employer Telephone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emerg. Contact Telephone: \_\_\_\_\_

## Responsible Party (If the patient is the responsible party you do not need to fill out this section.):

Responsible Party Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(First) (Middle Initial) (Last) (mm/dd/yy)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work/Other Telephone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Telephone Number: \_\_\_\_\_

## Insurance Information:

Primary Insurance Name: \_\_\_\_\_ Insured ID: \_\_\_\_\_

Insured Group Number: \_\_\_\_\_ Insured Social Security Number: \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Insured ID: \_\_\_\_\_

Insured Group Number: \_\_\_\_\_ Insured Social Security Number: \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**\*Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Appointments billing to a Motor Vehicle Accident or a Workers' Compensation Claim please fill out the following:

Work. Comp. or Motor Vehicle Accident Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Workers' Compensation Information/ Motor Vehicle Accident Information:

Work Comp. Status: Accepted  Deferred  Closed  Date of Injury or Accident: \_\_\_\_\_

Injury: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Adjustor Name: \_\_\_\_\_ Adjustor Telephone Number: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Attorney Telephone Number: \_\_\_\_\_