PORTLAND
8605 SW Terwilliger Blvd
Portland, OR 97219
Ph (503) 478-0600
Fx (503) 478-0602
Email: sarah@astepforwardpdx.com

SALEM
744 Hawthorne Ave. NE
Salem, OR 97301
Ph (503) 798-4988
Fx (503) 798-4989
Email: darrel@astepforwardpdx.com

PATIENT REGISTRATION

PATIENT NAME ______________________ ☐ MALE ☐ FEMALE HT ______ WT ______

HOME ADDRESS ______________________ SS# ______

CITY/STATE ______ ZIP CODE ______ DATE OF BIRTH ___/___/___

PREFERRED PHONE ______ OTHER PHONE ______ EMAIL ______

EMERGENCY CONTACT / RELATIONSHIP ______________________ PHONE ______

PHYSICIAN INFORMATION

REFERRING PHYSICIAN ______________________ PHONE ______

ADDRESS ______________________

PRIMARY PHYSICIAN ______________________ PHONE ______

ADDRESS ______________________

IF UNDER 18 YEARS OF AGE

GUARDIAN'S NAME ______________________ PHONE ______

INSURANCE INFORMATION

PRIMARY CARRIER ______________________ POLICY / ID NUMBER ______

GROUP NUMBER ______ INSURED NAME ______

INSURED DATE OF BIRTH ___/___/___ INSURED SOCIAL SECURITY NUMBER ___-___-___

RELATIONSHIP TO PATIENT ______________________

AUTHORIZATION

I hereby authorize the release of information regarding my condition/treatment, as necessary, to process these and/or related claims. I understand that I am responsible for all fees not covered by private insurance, Medicaid, Medical Assistance, other Governmental Agencies, or Worker's Compensation.

SIGNATURE ______________________ ___/___/___

PRINT NAME ______________________