PATIENT REGISTRATION

PLEASE PRINT

REFERRING DOCTOR: _____

PATIENT NAME: _____ DATE OF BIRTH:_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOBILE PH: _____ WORK PH: _____

SOCIAL SECURITY # _____ EMPLOYER: _____

EMERGENCY CONTACT/RELATION: _____/_____ PH: _____

AT WHAT PHONE # MAY WE LEAVE A DETAILED MESSAGE? HOME PH. MOBILE PH. WORK PH.

PRIMARY MEDICAL INSURANCE INFORMATION -PLEASE GIVE US YOUR INSURANCE CARDS & ID SO THAT WE MAY MAKE A COPY.

PRIVATE INSURANCE CO: _____ PH: _____

INSURED NAME: _____ GROUP # _____ ID: _____

SECONDARY MEDICAL INSURANCE INFORMATION

PRIVATE INSURANCE CO: _____ PH: _____

INSURED NAME: _____ GROUP # _____ ID: _____

CIRCLE ONE: PRIVATE INSURANCE MEDICARE MOTOR VEHICLE WORKMANS' COMP

***IF A WORK RELATED INJURY OR A MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FORM ON THE BACK OF THIS PAGE**

ALL PATIENTS: FOR OUR RECORDS, PLEASE READ THE FOLLOWING AND SIGN BELOW WHERE INDICATED.

I HEREBY AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS AND AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO NORTHWEST NEUROSURGICAL ASSOCIATES LLC. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ANY BALANCE ON MY ACCOUNT REGARDLESS OF INSURANCE COVERAGE AND/OR LITIGATION THAT MY BE PENDING.

IF I DO NOT SIGN THIS AGREEMENT, I UNDERSTAND THAT PAYMENT WILL BE MADE AT TIME OF SERVICE.

PATIENT'S SIGNATURE: _____ DATE: _____

***ATTENTION MEDICARE PATIENTS, PLEASE READ AND SIGN THE FOLLOWING FOR MEDICAL BILLING:**

I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE EITHER TO ME OR TO THE PROVIDER ON ANY BILLS FOR SERVICES FURNISHED TO ME, AND I AUTHORIZE NORTWEST NEUROSURGICAL ASSOCIATES TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS CLAIM OR ANY RELATED MEDICARE CLAIM. I FURTHER PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

PATIENT'S SIGNATURE: _____ DATE: _____

FOR OFFICE USE: ACCOUNT NUMBER: _____

FRANCISCO X. SOLDEVILLA, MD **501 N. GRAHAM ST. SUITE 445** **PORTLAND, OR 97227**

***IF A WORK RELATED INJURY OR A MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FOLLOWING:**

INSURANCE CO./ADDRESS: _____

DATE OF INJURY: _____ CLAIM #: _____ POLICY #: _____

ADJUSTER/AGENT NAME: _____ ADJUSTER PHONE: _____

ADJUSTER FAX #: _____ EMPLOYER WHEN INJURED: _____

_____

IF YOUR CLAIM IS IN LITIGATION, PLEASE COMPLETE THE FOLLOWING:

ATTORNEY NAME: _____ PHONE: _____ FAX: _____

_____

INFORMATION FOR THE DOCTOR

PLEASE PRINT

TODAY'S DATE: _____

NAME: _____ AGE: _____ WEIGHT: _____ HEIGHT: _____

REASON FOR CONSULTATION: _____

HOW DID YOU HEAR ABOUT US? _____

REFERRIING DR: _____ PRIMARY CARE DR: _____

OCCUPATION: _____ HOW LONG: _____ PREVIOUS OCCUPATION: _____

CURRENT MARITAL STATUS: _____ NUMBER OF CHILDREN: _____

OTHER MEDICAL PROBLEMS (HEART DISEASE, DIABETES, HYPERTENSION, ECT.): _____

_____

DO YOU CURRENTLY HAVE A PAIN MEDICINE CONTRACT/AGREEMENT W/ YOUR PRIMARY CARE DR.? NO ____ YES ____

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO: _____

_____

ARE YOU CURRENTLY TAKING ASPRIN? NO _____ YES _____ ARE YOU ALLERGIC TO IODINE OR TAPE? _____

DO YOU CURRENTLY USE TOBACCO? NO _____ YES _____ DAILY AMOUNT?_____

IF YOU USED TOBACCO IN THE PAST, WHEN DID YOU QUIT? _____ DAILY AMOUNT & HOW LONG? _____

DO YOU DRINK ALCOLOLIC BEVERAGES? NO _____ YES _____

IF YES, PLEASE EXPLAIN TYPE, AMOUNT, AND HOW LONG: _____

HAVE YOU EVER EVER HAD ANY DRUG DEPENDENCY PROBLEMS? NO _____ YES _____

IF YES, PLEASE EXPLAIN: _____

	ALIVE	DECEASED	CAUSE OF DEATH
MOTHER:	_____	_____	_____
FATHER:	_____	_____	_____

IS THERE ANY FAMILY HISTORY OF NEUROLOGICAL ILLNESS? NO _____ YES _____

IF YES, PLEASE EXPLAIN: _____

HAS THERE BEEN ANY RECENT INJURY, ILLNESS, INFECTION, OR WEIGHT LOSS? PLEASE EXPLAIN: _____

_____

_____

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