Advanced Orthopedic & Sports Medicine Institute, LLC
620 NW 11th St, Ste 201
Hermiston, OR 97838
(541)289-7075

Patient Information

Date: ____________________ Patient Name: ____

Address: ____

Home Phone: ________________ Cell Phone: ________________ Work: ____________________

Sex: M F SSN: ________________ DOB: ________________ Age: _______ Marital Status: ______

Employer: __________________________ Phone: _______________ Occupation: _____________

Employer's Address: ____

Spouse's Name: __________________________ Spouse's Employer: _______________________

Responsible Party: ________________________ Phone: ________________ DOB: ____________

Relationship to Patient: ___________________________ SSN: _________________________

Address: ____

Emergency Contact: ______________________________ Phone: ________________________

Primary Insurance

Insurance Company: _____________________________ ID Number: ______________________

Subscriber: ________________________________ Group Number: ______________________

Secondary Insurance

Insurance Company: __________________________________ ID Number: _________________

Subscriber: __________________________________ Group Number: ________________

Worker's Compensation

Insurance Company: ______________________________ Claim Number: ____________________

Date of Injury: ______________________________ Adjuster (if known): ____________________

Employer at time of injury: ____

ASSIGNMENT & RELEASE: I hereby authorize payment directly to Advanced Orthopedic & Sports Medicine Insitute, LLC all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance for all services rendered on my behalf or my dependents. I authorize the above noted doctor to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNED: ____ **DATE:** ______________________