INSTITUTE OF DIABETES & ENDOCRINOLOGY, PC

221 STEWART AVENUE, SUITE 101, MEDFORD OREGON, 97501
Phone: 1-541-776-2003 Fax: 1-541-776-9833

PATIENT INFORMATION TODAY'S DATE: ________________________

Legal Name____
Last First Middle

Home Phone______________________ Work Phone ______________________
Cell Phone______________________ E-Mail Address______________________
Address____
Street or PO Box City State Zip

Date of Birth______________________ Social Security # (required) ______________________
Marital Status______________________ Sex: Male__________ Female___________
Employer______________________ Occupation______________________
Have you ever received medical treatment under another name? ______________________

Emergency Contact (non-family member, outside of your home)

Name______________________ Contact Phone ______________________

Spouse / Guardian

Legal name ____
Last First Middle

Home Phone______________________ Work Phone ______________________
Cell Phone______________________ E-Mail Address______________________
Address____
Street or PO Box City State Zip

Date of Birth______________________ Social Security # (required)______________________
Employer______________________ Occupation______________________

Insurance Information

How do you intend to pay for your visit?

Cash _____ Check _____ Credit Card _____ Insurance _____ Medicare _____ Oregon Health Plan _____ Other _____

Primary Health Insurance:

Company ____
Mailing Address ____
Policy Number ______________________ Group Number ______________________
Insured Name ______________________ Relationship to Patient ______________________
Insured Social Security # (required) ______________________ Insured DOB (required) ______________________

Secondary Health Insurance:

Company ____
Mailing Address ____
Policy Number ______________________ Group Number ______________________
Insured Name ______________________ Relationship to Patient ______________________
Insured Social Security # (required) ______________________ Insured DOB (required) ______________________

ASSIGNMENT OF INSURANCE BENEFITS - The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted of behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted. This is for myself and/or dependents under 18. In addition, this signature will bind me as though the undersigned had personally signed the particular claim. I also understand that the Institute of Diabetes & Endocrinology, PC will accrue an interest charge of 9% annually on all unpaid bills over 90 days. By my signature I attest that I agree to the terms listed above and that all the information I have submitted is true and complete to the best of my knowledge.

____ ______________________
Signature of Patient or Legally Authorized Representative Date