## Patient Registration

PLEASE PRINT

Last Name: **TEST**

First Name: **TAMMY**

Middle Name:

Sex: **F** Date of Birth: **01/02/1969**

Social Security No.:

Address: **3125 MY ADDRESS/APT 21**

Zip: **97225**

City: **PORTLAND** State: **OR**

Home Phone: **(503) 416-9922**

Work Phone:

Mobile Phone: ( ) _____ - _____

Marital Status: SINGLE

Emergency Contact Information

Name:

Phone:

Employer Information

Name:

Phone:

Guarantor Information (to whom statements are sent)

Name: **TAMMY TEST**

Address: **1254 OLD ADDRESS**
**BEAVERTON, OR 97008**

Phone: ( ) _____ - _____

Other:

Patient Referred by:_____

Patient PCP:_____

## Primary Insurance Information

Insurance Plan Name: **PROVIDENCE HEALTH PLAN - PEBB - OPEN OPTION (EPO)**

Insurance Phone Number: **( )**_____-_____

Policy Information

Patient's relationship to policy holder:_____

ID/Certification No.: **10066534300**

Policy/Group No.:**106528**

Issue Date: _____

Exp Date:_____

Copay Amount:_____

Co-insurance Percent:_____

Address to Send Claims:**PO BOX 3125**

**PORTLAND, OR 97208-3125**

Policy Holder

Last Name:**TEST**

First Name:**TAMMY**

Middle Name:

Address:**3125 MY ADDRESS**

City: _____ State:**OR** Zip:**97225**

Social Sec Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: **M** or **F**

Employer:_____

## Secondary Insurance Information

Insurance Plan Name:

Insurance Phone Number: **( )**_____-_____

Policy Information

Patient's relationship to policy holder:_____

ID/Certification No.:

Policy/Group No.:

Issue Date: _____

Exp Date:_____

Copay Amount:_____

Co-insurance Percent:_____

Address to Send Claims:

,

Policy Holder

Last Name:

First Name:

Middle Name:

Address:

City: _____ State: Zip:

Social Sec Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: **M** or **F**

Employer:_____

**ASSIGNMENT AND RELEASE:**

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services.**
- **I authorize the physician to release any information required to process this claim.**

**Signed**_____ **Date:**_____