CASCADE PHYSICIANS, P.C.

PATIENT INFO

Last Name:	First Name:	Middle Initial:
Preferred Name:	Date of Birth:	Sex:
Address:	Social Security #:	
City: State: Zip:	Marital Status: ☐Single ☐Married ☐Partner ☐Widowed ☐Divorced	
Primary phone: ☐Mobile ☐Ok to leave detailed message?	Race: ☐White ☐African American ☐Asian ☐Other ☐Hispanic ☐Native American ☐Refuse to Report	
Secondary phone: ☐Mobile ☐Ok to leave detailed message?	Ethnicity: ☐Hispanic ☐ Non-Hispanic ☐ Refused to Report	
Work Phone: Ext:	Employer Name and Address:	
Email:		
Do you have an Advanced Directive or POLST? ☐Yes ☐ No	Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Not employed	

EMERGENCY CONTACT

■ Patient Here

Last Name: First Name: MI:	☐Spouse ☐Partner ☐Friend ☐Child ☐Parent ☐Other:
☐ Okay to leave a detailed message with this contact / Phone 1:	Phone 2:
Address (if different from patient):	Date of Birth:

ADDITIONAL EMERGENCY CONTACT

■ Patient Here

Last Name: First Name: MI:	☐Friend ☐Child ☐Parent ☐Other:
☐ Okay to leave a detailed message with this contact / Phone 1:	Phone 2:
Address (if different from patient):	Date of Birth:

PRIMARY INSURANCE

Insurance Company Name:	ID Number:	Group Number:
Claims Address:		Claims Phone Number:
Primary Subscriber Name (if different from patient):	Date of Birth:	Relationship to patient: ☐Spouse ☐Partner ☐Parent ☐Other:
Phone 1:	Phone 2:	Social Security #:

If you have more than one insurance plan, please make sure to provide that information to the office at the time of service.

PREFERRED PHARMACY

Pharmacy Name:	Pharmacy Phone Number:	Pharmacy Fax Number:
Pharmacy Address:		City, State, Zip:

Payment is due at time of service. If patient is covered by insurance, the insurance company will be billed. It is your responsibility, however, to pay your portion at the time of the service. If necessary, please discuss other financial arrangements with our billing office. Finance charges will be assessed after 90 days. Visa and MasterCard are available for your convenience.

I acknowledge that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of amount due, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

SIGNATURE:

Patient Signature (or Guardian):	Date:
Whom may we thank for referring you?	Relationship: