

Salem Pulmonary Associates

801 Mission Street SE

Salem, OR 97302

503-588-3945

Completion of the information in its entirety is required at the time of visit.

A. Patient Information

Name: _____ SSN: _____

Last

First

Middle

Date of Birth: ____/____/____

Email: _____

Home Address: _____

Street

City/State

Zip

Home Phone: (____) _____

Work Phone: (____) _____

May we leave a message at your home? YES NO

At your place of employment? YES NO

Marital Status: Single Married Divorced Separate

Race: _____

Language: _____

Occupation: _____

Employer: _____

Employer Address: _____

Street

City/State

Zip

B. Spouse/Parent Information/Other Responsible Person

Name: _____ SSN: ____/____/____

Last

First

Middle

Date of Birth: ____/____/____

Relationship: _____

Address: _____

Street

City/State

Zip

Phone: (____) _____

Work Phone: (____) _____

Employer: _____

Employer Address: _____

Street

City/State

Zip

C. In Case of Emergency

Relative to Contact (other than spouse): _____

Relationship: _____

Phone: (____) _____

Other person to contact (not a relative): _____

Relationship: _____

Phone: (____) _____

D. Method of Payment Cash Check Credit Card Insurance Other

Primary Insurance Co.: _____

Address: _____

Phone: (____) _____

Name of Insured: _____

Date of Birth: _____

Policy #: _____

Group #: _____

Secondary Insurance Co.: _____

Address: _____

Phone: (____) _____

Name of Insured: _____

Date of Birth: _____

Policy #: _____

Group #: _____

E. Reason for This Visit: Who referred you to this office? _____

Illness Injury Job-related Injury Auto Accident Other: _____

Date of Injury or onset of problem: _____ Symptoms: _____

Worker's Compensation Carrier: _____ Phone: (____) _____

F. Please sign and return to receptionist upon completion

I acknowledge that I am financially responsible for all charges whether or not they are covered by my insurance. I understand and agree that health Insurance policies are an arrangement between an insurance carrier and myself and that my doctor and/or his staff are not the administrators of the policy. I authorize payment of medical benefits to Salem Pulmonary Associates PC and my doctor for medical services rendered. A photocopy of the signature is as valid as the original.

If it becomes necessary to effect collections for any amount owed on this or subsequent visits. The undersigned agrees to pay for all the costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. Any check returned to Salem Pulmonary Associates PC due to non-sufficient funds will be charged a fess of \$25.00.

I also understand that during the course of normal business Salem Pulmonary Associates PC may need to electronically transmit (fax) my medical records. I hereby authorize such transmission and absolve Salem Pulmonary Associates PC, its physicians, and its employees of any and all liability relating to such transmission of records.

Signature: _____

Date: _____