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:**________________