

**LAKE OSWEGO FAMILY PHYSICIANS
REGISTRATION FORM**

Today's date:				PCP: (Please Print)			
PATIENT INFORMATION							
Patient's Legal last name: (Please Print)		First: (Please Print)		Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Marital status (circle one) Single / Mar / Div / Sep / Widow
Birth date:		Age:	Sex:	Social Security no.:		Home Phone #:	
/ /			<input type="checkbox"/> M <input type="checkbox"/> F			()	
Street address/P.O. Box:				City:		State:	Zip Code:
Mobile Phone #:			Employer:			Work Phone #:	
RESPONSIBLE PARTY INFORMATION							
Person responsible for bill:		Birth date:		Address (if different):			Home phone no.:
		/ /					()
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:		Employer address:			Employer phone no.:	
						()	
PRIMARY INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)							
Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
PLEASE INDICATE PRIMARY INSURANCE BY CHECKING THE APPROPRIATE BOX:							
<input type="checkbox"/> Blue Cross/Blue Shield		<input type="checkbox"/> Aetna		<input type="checkbox"/> Medicare		<input type="checkbox"/> Providence	<input type="checkbox"/> United Health Care <input type="checkbox"/> Healthnet
<input type="checkbox"/> ODS	<input type="checkbox"/> Great West	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other. If Yes, Name:				
Subscriber's name:		Subscriber's S.S. no.:		Birth date:	Policy no.:		Group no.:
				/ /			
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SECONDARY INSURANCE INFORMATION							
Name of secondary insurance (if applicable):			Subscriber's name:			Policy no.:	Group no.:
Patient's relationship to subscriber:			<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):				Relationship to patient:		Contact #:	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize LOFP or insurance company to release any information required to process my claims.							
Patient/Guardian signature						Date	