

**Cascade Orthopedics &  
Sports Medicine Center, P.C.**  
1715 East 12<sup>th</sup> Street , The Dalles, Oregon 97058  
541-296-2294

**PATIENT INFORMATION**

Date \_\_\_\_\_ Acct # \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_

**PATIENT  
INFORMATION**

Name \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_  
Street or PO BOX City State Zip

Telephone No.: Home \_\_\_\_\_ Alternate \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ SSN \_\_\_\_\_

**PATIENT'S Employer Name** \_\_\_\_\_ Occupation \_\_\_\_\_

Employers Address \_\_\_\_\_ Phone No.: \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Spouse's Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

**If child:** Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Self \_\_\_ Spouse \_\_\_ Parent/Guardian \_\_\_

**PERSON  
RESPONSIBLE  
FOR  
PAYMENT**

Name \_\_\_\_\_ SSN \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State Zip

Telephone No.: Home \_\_\_\_\_ Alternate \_\_\_\_\_

**EMERGENCY  
CONTACT**

Spouse/Significant Other/Partner \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact Individual \_\_\_\_\_ Phone \_\_\_\_\_ Relation: \_\_\_\_\_  
(Not living with you)

**INSURANCE CARD COPIES ARE REQUIRED**

**PRIMARY  
INSURANCE**

Ins. Company \_\_\_\_\_ ID No.: \_\_\_\_\_

Policy or Group No.: \_\_\_\_\_

Address \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**SECONDARY  
INSURANCE**

Ins. Company \_\_\_\_\_ ID No.: \_\_\_\_\_

Policy or Group No.: \_\_\_\_\_

Address \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I acknowledge that I am financially responsible for all charges, If it becomes necessary to effect collection of any amount owed on this or subsequent visits, I agree to pay all costs and expenses, including reasonable attorney fees. I understand that any **Co-Pays are due at the time of visit** according to any contract with my insurance company. I understand that I must provide proof of coverage for **OMAP/DSHS** (Copy of Voucher) and fulfill referral requirements at each visit. I have reviewed an outline of the billing and payment requirements of Cascade Orthopedics & Sports Medicine Center, P.C. All accounts over 90 days will be charged a \$25.00 collection fee. I have read and understand the financial policy and accept this policy for my treatment.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

FOR OFFICE USE ONLY

**Updated Info/Signature:** \_\_\_\_\_  
(Initial and Date)