819 SE Morrison St. Suite 115
Portland, OR 97214

Phone: 503-956-9396
Fax: 503-206-4791

Patient Demographic Information

Full Legal Name:______________________________ Date: ____________

Address: ______________________ City: ____________ State: ________ Zip code: __________

Phone: Day/______________ Evening/ ____________ Cell/ ______________ May we leave a message? ❑ Y ❑ N

E-mail: ______________________________ Age: __________ Date of birth: ______________

Do you agree to email as a form of communication regarding your treatment or billing? ❑ Y ❑ N

- What is your birth sex? ❑ Male ❑ Female ❑ Other (please specify)__________________
- What gender do you identify as? ❑ Male ❑ Female ❑ Other (please specify)__________________
- What is your preferred pronoun? ❑ He ❑ She ❑ Other (please specify)__________________
- Marital status: ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed ❑ Single
- Housing: ❑ Spouse/Partner ❑ Parents ❑ Children ❑ Friend/Roommate ❑ Alone

Occupation: ______________________________ Hours per week: ______________ Retired: ❑ Y ❑ N

Emergency contact: ______________________________ Relationship: ________________

Phone: ____________________ E-mail: ______________________________

How did you hear about us? ❑ Insurance ❑ Walking by ❑ Website ❑ Blog ❑ Event (please specify)
______________________ ❑ Referred by ______________________________

Billing Information

Because every medical plan is different, it is always best for you to verify your plan and become familiar with your benefits so you know what you can expect to pay for services rendered. To do this, start by calling the number listed on the back of your insurance card.

A **comprehensive** toolkit, "How to Check Your Medical Benefits," is available on our website www.HeartSpringHealth.com under the Clinic Info Tab for your convenience. We highly recommend you complete this toolkit before your first appointment at HSH.

Primary Insurance Company & Plan Name:______________________________________

ID#:____________________ Group/Policy#: __________________ Co-pay/Co-insurance: __________

Name of policy holder ______________________________ Policy holder's date of birth: ___/____/_____

Relationship of policy holder to patient: ____________________

If you are being seeing for a Motor Vehicle Collision or Workman Comp. case:

Insurance Company: ______________________________________

Policy # ______________________ Claim #: ______________________

Adjuster's name: ______________________ Adjuster's Phone #: ________________

Date of Incident: ______________________ Claim Start Date: ________________