Veneta
Medical Clinic

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone/cell phone: ( ) ( )		
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone: ( )				
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Patient email address:						
Other family members seen here:						
INSURANCE INFORMATION						
Please bring your insurance card to your appointment						
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )			
Is this person a patient here?	❑ Yes	❑ No				
Occupation:	Employer:	Employer address:	Employer phone no.: ( )			
Is this patient covered by insurance?	❑ Yes	❑ No				
Please indicate primary insurance	❑ Regence Blue Cross	❑ PacificSource	❑ HealthNet	❑ United Healthcare	❑ Aetna	
❑ Medicare	❑ ODS	❑ Workers Comp	❑ Other (please list)			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:			
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )			

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 or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date