SHELDON COBER, M.D.
AUSTIN HAYES, M.D.
PATIENT INTAKE FORM
(PLEASE PRINT)

PATIENT INFORMATION

NAME: TOMMY TEST AGE: 4 YR DRIVER'S LICENSE:
ADDRESS: 18650 NW CORNELL RD PORTLAND, OR 97124
HOME PHONE: (503) 601-7007 WORK PHONE:
CELL PHONE:
DATE OF BIRTH: 06/14/2010
Male Female
OCCUPATION:
Single Married Divorced Other
EMPLOYER:
PRIMARY CARE PHYSICIAN: PHONE:
EMERGENCY CONTACT PERSON: PHONE:
ADDRESS: CITY: ZIP CODE:
IF CHILD/MINOR, PARENT/GUARDIAN NAME:

INSURANCE INFORMATION

PRIMARY INSURANCE: *SELF PAY*
SECONDARY INSURANCE:
SUBSCRIBER: SUBSCRIBER:
SUBSCRIBER DOB: SUBSCRIBER DOB:
RELATION TO PATIENT: RELATION TO PATIENT:
ID NUMBER: ID NUMBER:
GROUP NUMBER: GROUP NUMBER:
SOCIAL SEC.#: SOCIAL SEC. #:
INSURANCE CO. ADDRESS: INSURANCE CO. ADDRESS:
CITY: ST. ZIP: CITY: ST. ZIP:

WORKERS COMPENSATION INFORMATION

EMPLOYER AT TIME OF INJURY: OCCUPATION:
EMPLOYERS ADDRESS: CITY: STATE:
DATE OF INJURY/ACCIDENT: CLAIM #:
COMP. INSURANCE COMPANY:
ADDRESS: CITY: ZIP CODE:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HERE BY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN, AND AUTHORIZE RELEASE OF ANY IN FORMATION NECESSARY TO PROCESS THIS CLAIM. A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

X DATE::