Women's Health Today

Providence Professional Plaza
5050 N.E. Hoyt, Suite 362
Portland, Oregon 97213
503-239-6800

Maxine Bauer, M.D.	
Desiree Bley, M.D.	
Anika Denali Luengo, M.D.	
Janet Gibbens, M.D.	
Nancy Grant, M.D.	
Oscar Polo, M.D.	
Liana Corliss, F.N.P.	
Hannah Litt, C.N.M.	

ACCOUNT NUMBER

DATE / /

PRIMARY CARE PHYSICIAN

PATIENT INFORMATION *(Please Print)*

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME	BIRTHDATE / /
PATIENT'S ADDRESS			
CITY	STATE		ZIP CODE
PATIENT'S PHONE	BEST NUMBER TO REACH YOU		PATIENT'S SOCIAL SECURITY NUMBER
PATIENT'S EMPLOYER	EMPLOYER PHONE NUMBER		OCCUPATION
PREFERRED PHARMACY NAME	PHARMACY PHONE NUMBER		PERSONAL EMAIL ADDRESS
MARITAL STATUS	DRIVER'S LICENSE #	RACE/ETHNICITY	HOW DID YOU HEAR ABOUT US?

RESPONSIBLE PARTY'S INFORMATION *(Name of person to whom bill should be sent)*

LAST NAME	FIRST NAME	MIDDLE NAME	BIRTHDATE / /	RELATIONSHIP TO PATIENT
BILLING ADDRESS (If different than patient's)				
CITY	STATE	ZIP CODE	HOME PHONE NUMBER	

PERSONAL INSURANCE INFORMATION - PRIMARY

Insurance Co. _____ Subscriber _____

Address _____ Subscriber Date of Birth _____

Group # _____ ID # _____ Employer _____

Relationship _____

SECONDARY INSURANCE

Insurance Co. _____ Subscriber _____

Address _____ Subscriber Date of Birth _____

Group # _____ ID # _____ Employer _____

Relationship _____

NAME OF FRIEND OR RELATIVE OR GUARDIAN OR PARENT - NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

Name _____ Relationship _____

_____ Phone _____

****AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS****

I authorize payment of medical benefits to Maxine Bauer, M.D., Desiree Bley, M.D., Anika Denali Luengo, M.D., Janet Gibbens, M.D., Nancy Grant, M.D., Oscar Polo, M.D., Liana Corliss, F.N.P., and/or Hannah Litt, C.N.M. I also authorize the release of any medical information necessary to process this claim. I understand that I am financially responsible to the Providers for charges not covered by my insurance plan. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

_____ SIGNATURE

_____ DATE