PORTLAND URGENT CARE
portlandurgentcare.com
contact@portlandurgentcare.com
fax: 503-719-6829

PORTLAND WELLNESS CARE
portlandwellnesstcare.com
contact@portlandwellnesscare.com
fax: 503-477-9958

4160 NE SANDY BLVD., PORTLAND, OR 97212 503-249-9000

PATIENT REGISTRATION INFORMATION

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

DATE _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____
DATE OF BIRTH _____ SEX M ☐ F ☐
MARITAL STATUS S ☐ M ☐ W ☐ D ☐ OTHER _____ SPOUSE NAME _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
EMAIL ADDRESS _____

HOW DID YOU HEAR ABOUT US? _____

EMPLOYER _____ WORK PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

RESPONSIBLE PARTY INFORMATION *(for patients under 18 and other dependent patients)*

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____
RELATIONSHIP TO PATIENT _____
DATE OF BIRTH _____ SEX M ☐ F ☐
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
EMAIL ADDRESS _____

EMERGENCY CONTACT

LAST NAME _____ FIRST NAME _____
RELATIONSHIP TO PATIENT _____ PHONE _____

PATIENT PRIMARY CARE PROVIDER

NAME _____ CLINIC _____
ADDRESS _____ PHONE _____

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE POLICY _____	SECONDARY INSURANCE POLICY _____
NAME OF POLICY HOLDER _____	NAME OF POLICY HOLDER _____
POLICY # _____ GROUP # _____	POLICY # _____ GROUP # _____
DATE OF BIRTH _____	DATE OF BIRTH _____
RELATIONSHIP TO PATIENT _____	RELATIONSHIP TO PATIENT _____