

WOMEN'S HEALTH TODAY

Providence Professional Plaza
5050 N.E. Hoyt, Suite 421
Portland, Oregon 97213
(503) 239-6800

Maxine Bauer, M.D.	
Desiree Bley, M.D.	
Janet Gibbens, M.D.	
Nancy Grant, M.D.	
Oscar Polo, M.D.	
Liana Corliss, F.N.P.	
Karen Parker Linn, 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		MESSAGE PHONE		PATIENT'S SOCIAL SECURITY NUMBER	
PATIENT'S EMPLOYER		EMPLOYER'S PHONE NUMBER	OCCUPATION		

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 <i>(If different than patient's)</i>						
CITY			STATE	ZIP CODE	HOME PHONE NUMBER	

PERSONAL INSURANCE INFORMATION - PRIMARY

Insurance Co. _____ Subscriber _____
 Address _____ Subscriber Date of Birth _____
 Group # _____ I.D. # _____ Employer _____
 Relationship _____

SECONDARY INSURANCE

Insurance Co. _____ Subscriber _____
 Address _____ Subscriber Date of Birth _____
 Group # _____ I.D. # _____ 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., Janet Gibbens, M.D., Nancy Grant, M.D., Oscar Polo, M.D., Karen Parker Linn, C.N.M. and/or Liana Corliss, F.N.P. 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