Contact Information
(PLEASE PRINT CLEARLY)

Patient Name _____
Last First Middle initial

Date of Birth: Month_____Day_____Year_____

Home address _____

City _____ State _____ Zip _____

Driver's License # _____ State _____

Primary phone: Daytime ( ) _____ Evening ( ) _____

Cell phone ( ) _____ Fax ( ) _____

Email address _____ Skype Contact: _____

Employed by _____ Occupation _____

Insurance Provider _____ If PPO Plan do you wish to have a diagnostic code receipt so you may seek reimbursement Yes _____No _____

What name do you prefer to be called?
_____
Who referred you to our office?
_____

In case of emergency contact:

Name _____ Relationship _____

Address _____

City _____State _____ Zip _____

Home phone ( ) _____ Work phone ( ) _____

For children under 18 years of age:

Father's full name _____

Mother's full name _____

School attending _____ City _____

Credit Card Authorization

I, (print name) _____authorize Sunrise Medical Center (SMC) , located at 750 NW Charbonneau Street #201, Bend OR 97701 (mailing address) to bill my credit card as listed below.

Name on Credit Card _____

Credit Card Details

Card Type: _____Visa _____MasterCard _____Amex _____ Discover

Card # _____ Exp date _____

CVV Code:_____

Zip Code where credit card statement is mailed:_____

Card Holder Information—billing address

Name: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone (include area code): _____

Patient's Name (authorized for charges)_____

Authorization

_____ _____

Card Holder's Signature Today's Date

_____ _____

Patient's Signature Today's Date

This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.