



Bend Osteopathic Care, PC

147 SW Shevlin Hixon Dr Ste 204, Bend, OR 97702
O: 541.706.9985 F: 541.408.9853
www.drkyle.com

Demographics

Today's Date: _____ Patient Name: _____ Age: _____ M F

Birth Date: ____/____/____ Hm Ph: _____ Cell Ph: _____ Email Address: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address (If different from above): _____

Occupation: _____ Employer: _____ Work Phone: _____

May we contact you at Work: Y N N/A How Did You Learn/Hear About Our Practice: _____

Emergency Contact: _____ Relationship: _____ Contact Phone: _____

Primary Care Physician: _____ PCP Phone: _____

Financial & Insurance Information:

Please **Tick** appropriate box: I will pay my balance in full at time of service. Please bill my insurance; I will present my card.

Primary Insurance Co: _____ ID#: _____ Group# _____

Secondary/Insurance Co: _____ ID#: _____ Group# _____

Complete the following about **Insured** if not self: Name: _____ M F Birth Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____ Relationship to Insurer: Spouse/Partner Child

Complete if Motor Vehicle Accident or Workers Compensation is to be billed:

Insurance Co Responsible for Claim: _____ Claim Number: _____ Date Injured: _____

Adjuster's Name: _____ Ph: _____ Fax: _____ Email: _____

Records Release & Assignment of Insurance Benefits:

The undersigned hereby authorizes the **Release of Information** relating to claims for benefits submitted. **I agree and acknowledge that I authorize my physician to submit claims for benefits to appropriate insurance company, for services rendered, without obtaining my signature on each claim.**

I (Patient Name, **Pls Print**): _____ Hereby authorize (Your Insurance Co. Name): _____
to pay and assign directly to Bend Osteopathic Care, PC all owed benefits. I understand I am financially responsible for all charges incurred if my insurance does not pay.

Patient Signature (or Guardian Signature for patients under 18 Yrs)

Are you the Patient Yes or Other

DATE

Consent Form & Agreement:

Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician/practitioner does not explain to your satisfaction, please ask for more information. I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

Patient Signature (or Guardian Signature for patients under 18 Yrs)

Are you the Patient Yes or Other

DATE