Phone: 503.352.0240
Fax 971.279.5635
www.nhws.us

9400 SW Beaverton-Hillsdale Hwy.,
Suite 210, Beaverton, Oregon 97005

Patient Information and Insurance Form

☐ New Patient ☐ Change of Address ☐ Updated Insurance Info ☐ Returning Patient (after 3 months)

Patient Information

Patient Name: ______________________ D.O.B. __________ ☐ M ☐ F
First M.I Last

Phone Number(s)

Parent(s)/Responsible Party	Home	Work	Cell	Email
Mother Name:				
Father Name:				
Caregiver Contact Information:	Name			

Address: ______________________ ______________________
Street City, State Zip Code

Parents are: ☐ Married ☐ Separated ☐ Divorced Parenting Plan? ☐ Yes ☐ No

Physician's Information

Primary Physician: ______________________ Address: ______________________
Phone: ______________________

Referring Physician: ______________________ Address: ______________________
☐ *Same as above*
Phone: ______________________

Insured's Information

Name: ______________________ D.O.B. __________ ☐ M ☐ F
Last First

Employer: ______________________ S.S.N. ______________________

Insurance Company: ______________________ I.D. #: ______________________

Group #: ______________________

Insurance
Address: ______________________ ______________________ __________
Street City, State Zip

Insurance Phone Number: ______________________

Secondary Insurance Information

Name: ______________________ D.O.B. __________ ☐ M ☐ F
Last First

Employer: ______________________ S.S.N. ______________________

Insurance Company: ______________________ Subscriber: ______________________

Group #: ______________________

Assignment and Release: I hereby authorize New Horizons Wellness Services, LLC to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to New Horizons Wellness Services, LLC and I am financially responsible for any unpaid balance.

I declare the foregoing information is true and correct

______________________ ______________________
Print Name Date

______________________ ______________________
Responsible Party Signature Witness (to be signed by Staff Member)

ID Copied: ☐ Yes ☐ No