James J. Biemer, Jr., M.D., F.A.C.P.

9135 SW Barnes Rd, Suite 863, Portland, OR 97225
Phone: 503.384.0316 Fax: 503.416.8145

Patient Demographics

Name:

_____
Last First MI

Address:

_____
Street Apartment #

_____ _____ _____
City State Zip Code

Social Security #: _____ Birth Date: _____
(MM/DD/YYYY)

Phone: _____ _____ _____
Home Work Cell

Email: _____

Male _____ Female _____ Married _____ Single _____ Other _____

Primary Insurance Information

Insurance Company Name: _____

ID #: _____ Group #_____

Name of Insured: _____
Last First MI

Birth Date: _____ Patients Relationship to insured: Self ___ Spouse___ Child ___

Secondary Insurance Information

Insurance Company Name: _____

ID #: _____ Group #_____

Name of Insured: _____
Last First MI

Birth Date: _____ Patients Relationship to insured: Self ___ Spouse___ Child ____

Emergency Contact

Name:

_____
Last First MI

Address:

_____
Street Apartment #

_____ _____ _____
City State Zip Code

_____
Relationship to patient

Phone: _____ _____ _____
Home Work Cell

Authorization for treatment and financial agreement

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize James J. Biemer, MD to provide to my insurance companies all information necessary to process insurance claims and assign to James J. Biemer, MD all of the insurance benefits due to me to the full extent of my financial obligation.

Signature: _____ **Date:** _____