

Bours Health Center, P.C.
W.A. "Peter" Bours, M.D.
PATIENT REGISTRATION
(Please Print)

Date

PATIENT'S INFORMATION			
First Name (Miss, Mrs, Ms, Mr)	Middle Initial	Last Name	Social Security Number
Address		Date of Birth / /	Home Phone Number
City	State	Zip	Sex (Circle) M F
Your Occupation	Employer	Marital Status (Circle) S M D W	Cell Phone Number
		Employer Phone Number	

INSURANCE INFORMATION			
Subscriber's First Name	Middle Initial	Last Name	Social Security Number
Address		Sex (Circle) M F	Home Phone Number
City	State	Zip	Marital Status (Circle) S M D W
Name of Insurance Company	Policy or ID Number		Group Number
Relationship to Patient	Subscriber's Employer	Date of Birth / /	Subscriber's Occupation

DRIVER'S INFORMATION			
Name	Phone Number	Cell Phone	Relationship

INSURANCE AUTHORIZATION
<p>I HEREBY AUTHORIZE THE ABOVE DOCTOR/DOCTORS TO FURNISH THE INSURED'S INSURANCE COMPANY ALL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT CLAIM. I HEREBY ASSIGN TO THE DOCTOR ALL MONEY WHICH I AM ENTITLED TO FOR EXPENSE RELATIVE TO THE SERVICES PERFORMED FROM TIME TO TIME BUT NOT TO EXCEED MY INDEBTEDNESS TO SAID DOCTOR. IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE ABOVE NAMED INSURANCE COMPANY OVER AND ABOVE MY INDEBTEDNESS WILL BE REFUNDED TO ME WHEN MY BILL IS PAID IN FULL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO SAID DOCTOR FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. THE ABOVE INSURANCE INFORMATION MAY BE VERIFIED.</p>

PLEASE REMEMBER:

1. All information is confidential; we will not release any information without your written consent.
2. You must have a valid Oregon Medical card (welfare) with you on the day of your service if you want us to bill the State.
3. If you have insurance or Oregon welfare, we can bill them but we must have at least three days advance notice.
4. Payment in either cash, Visa or Mastercard (no checks) is due at the time of the service.
5. Your appointment will take two hours; plan accordingly. If your ride is planning on dropping you off and picking you up later, have them check with the receptionist before leaving.

THERAPEUTIC ABORTION QUESTIONNAIRE

Name _____ Date _____

Address _____

City _____ State _____ Zip _____ Date of Birth _____

Phone: Home _____ Cell _____ Work _____

HISTORY OF PRESENT PREGNANCY:

Date of first day of last period _____

Was it normal? (by flow and # of days) yes _____ no, describe _____

Place and date of pregnancy test/ultrasound _____

HISTORY OF PAST PREGNANCIES:

Dates* and outcomes of full term pregnancies _____

Dates* of previous miscarriages _____

Dates* and places of previous abortions _____

(*≈approximate dates, as best as you can remember)

PAST MEDICAL HISTORY:

Surgery _____

Serious Illnesses _____

Allergies _____

Last Pap Smear _____

Pelvic Infection (Uterine or Tubal?) _____

Sexually Transmitted Disease/HPV _____

Hepatitis/HIV _____

Present method of birth control _____

How did you first learn of our Center? _____

Patient's Signature _____