

Portland Family Practice  
541 NE 20<sup>th</sup> Ave- Portland Oregon 97232  
503-233-6940

Date: \_\_\_\_\_

**Contact Information:**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**Local Relative/Friend not living in the same household**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**By signing below, I agree I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

By: \_\_\_\_\_  
(Patient)

Date: \_\_\_\_\_

(OR)

By: \_\_\_\_\_  
(Patient representative)

Date: \_\_\_\_\_

**Description of Representative's Authority:** \_\_\_\_\_