

Are you (Please select one): a New Patient or an Established Patient

Name _____ DOB _____

Phone # _____ 2nd # _____

Seen at Hospital: Yes No If yes, please provide Date: _____

Name of Facility/Hospital: _____

Primary Care Physician Name: _____

Were you referred by your primary Care Physician: Yes No

Symptoms _____

Date of Injury _____ Body Part(s) _____

Neck/Back involved Yes No

Splinted: Yes No X-Rays taken: Yes No MRI: Yes No

Health Insurance _____ Referral Required Yes No
(If you are involved in a Workers Comp case or Motor Vehicle Accident, please be sure to complete the applicable section in the top left corner)

Please select the doctor with whom you are wanting to schedule: (Leave blank if any or next available is preferred)

- Dr. McWeeny Dr. Ballard
- Dr. Sedgewick Dr. Huberty
- Dr. Black Dr. Feinblatt

Please select which location you would prefer: Oregon City Tualatin

Have you been seen by another specialist?: Yes No
Type _____

Name of Specialist _____ City _____ State _____

Surgery Yes No Date _____ Type _____

Are you looking for:
2nd OP Transfer of Care 2nd OP/Possible Transfer

FOR WORKMAN'S COMP CASES

W/C Carrier _____ Phone # _____

Address _____

Claim # _____ Adjuster _____

Employer at time of injury _____

FOR MOTOR VEHICLE ACCIDENTS

MVA Insurance _____ Phone # _____

Address _____

Claim # _____ Adjuster _____

FOR OFFICE USE ONLY

W/C VERIFICATION

- Complete 827
- Sign Waiver
- Referral
- Deferred
- Closed
- Open
- Accepted
- Denied

Enrolled in MCO? Yes No

MCO Name: _____

MVA VERIFICATION

- PIP open & Available
- PIP Exhausted
- Expired
- Investigation
- Litigation

Verified By: _____ Date: _____

Notes/Directives: _____

MA Signature _____ Doctor Signature _____