

**GATEWAY WOMEN'S CLINIC**  
177 NE 102<sup>nd</sup> Ave, Portland, Oregon, 97220

NAME (FIRST MIDDLE LAST) \_\_\_\_\_ ID CHECKED: \_\_\_\_\_

OTHER NAME(S) YOU HAVE USED \_\_\_\_\_ PARENT/SPOUSE/PARTNER \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT) \_\_\_\_\_

CELL/MESSAGE PHONE \_\_\_\_\_ PARENT/SPOUSE/PARTNER PHONE \_\_\_\_\_  
(Which of these numbers, if any, can we leave a confidential voice mail? \_\_\_\_\_)

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

By initialing **here** \_\_\_\_\_ I authorize the use of e-mail for correspondence from Gateway Women's Clinic and understand the security risks involved in this form of communication.

EMAIL ADDRESS: \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ REFERRED BY \_\_\_\_\_

PRIMARY INSURANCE COMPANY \_\_\_\_\_ GROUP/ID \_\_\_\_\_

INSURANCE SUBSCRIBER NAME \_\_\_\_\_ RELATIONSHIP TO PT \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH \_\_\_\_\_ SUBSCRIBER SS NUMBER \_\_\_\_\_

INSURANCE EFFECTIVE DATE \_\_\_\_\_ 2<sup>ND</sup> INSURANCE \_\_\_\_\_

GROUP/ID \_\_\_\_\_ SUBSCRIBER NAME \_\_\_\_\_

RELATIONSHIP TO PT \_\_\_\_\_ SUBSCRIBER DATE OF BIRTH \_\_\_\_\_

SUBSCRIBER SS NUMBER \_\_\_\_\_ INSURANCE EFFECTIVE DATE \_\_\_\_\_

EMERGENCY CONTACT (NOT LIVING WITH YOU) \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD**

I understand that my signature authorizes my insurance to pay benefits directly to Gateway Women's Clinic, but that I am ultimately financially responsible for all medical services rendered, including services provided by an outside lab or other facility.

I understand that my signature authorizes my treating physician at Gateway Women's Clinic to obtain lab results and other information necessary for treatment.

I have received and signed a copy of the OFFICE AND FINANCIAL POLICY,

I have received a copy of the NOTICE OF PRIVACY PRACTICES for this clinic.

\_\_\_\_\_  
PATIENT /AUTHORIZED PERSON

\_\_\_\_\_  
DATE