Patient Registration Form

PATIENT LABEL HERE

REGISTRATION: PATIENT INFORMATION

Patient Name: ____ DOB: _______/_________/_______
Last First MI

Birth Gender: ❑ Female ❑ Male | Preferred Pronoun: ❑ she/ her/ hers ❑ he/ him/ his ❑ they/ them/ theirs ❑ Other _____________

Address: ____

City/State/Zip: ____ SSN: ________________________

Primary Phone: (___________)____________________________ *How would you prefer to receive appointment reminders?* ❑ Call **OR** ❑ Text

❑ Home Phone ❑ Mom Cell ❑ Dad Cell ❑ Patient Cell ❑ Other ________________________

Primary Email: ____ ❑ Patient ❑ Other ___________

PRIMARY GUARDIAN INFORMATION

____
Last First MI

DOB: _____/_____/_____ SSN: ___________________ ❑ F ❑ M

❑ **Address Same as Patient**

Address: ____

City/State/Zip: ____

Home Phone: (___________)_______________________ ❑ Primary

Cell Phone: (___________)_______________________ ❑ Primary

** Do we have your permission to leave a detailed and/or confidential voice message at the primary number?* ❑ Yes ❑ No

Email: ____

Relationship to Patient: ❑ Parent ❑ Step-Parent ❑ Foster ❑ Other: ______________________

Do you have Legal Custody and/or Authority of the Patient? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed

Employer & Occupation: ________________________________

Work Phone: (___________)_______________________

SECONDARY GUARDIAN INFORMATION

____
Last First MI

DOB: _____/_____/_____ SSN: ___________________ ❑ F ❑ M

❑ **Address Same as Patient**

Address: ____

City/State/Zip: ____

Home Phone: (___________)_______________________ ❑ Primary

Cell Phone: (___________)_______________________ ❑ Primary

** Do we have your permission to leave a detailed and/or confidential voice message at the primary number?* ❑ Yes ❑ No

Email: ____

Relationship to Patient: ❑ Parent ❑ Step-Parent ❑ Foster ❑ Other: ______________________

Do you have Legal Custody and/or Authority of the Patient? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed

Employer & Occupation: ________________________________

Work Phone: (___________)_______________________

CONTINUE ON NEXT PAGE

Patient Name: ____ Patient DOB: _______/_______/_______

SIBLING INFORMATION

Sibling Name: ____ DOB: ______/_______/_______ Our Patient? ❑ Yes ❑ No
Last First MI

Sibling Name: ____ DOB: ______/_______/_______ Our Patient? ❑ Yes ❑ No
Last First MI

Sibling Name: ____ DOB: ______/_______/_______ Our Patient? ❑ Yes ❑ No
Last First MI

Sibling Name: ____ DOB: ______/_______/_______ Our Patient? ❑ Yes ❑ No
Last First MI

EMERGENCY CONTACT INFORMATION (*OUTSIDE THE HOUSEHOLD*)

EMERGENCY CONTACT: ___________________________________ Relationship to Patient: __________________________________
Last First

Home Phone: (___________)______________________ ❑ Primary Cell Phone: (___________)______________________ ❑ Primary

See staff to complete an Authorization of Delegate (AOD) form if you wish to authorize this person to: schedule, confirm, cancel and/or accompany your child to visits.

BILLING & INSURANCE INFORMATION *(CHECK ALL THAT APPLY)*

❑ **No Insurance (Self Pay)**

PRIMARY INSURANCE

❑ Oregon Health Plan/ OHP/Medicaid
❑ Insurance through Employer or Private Policy

Company Name: ____

Policy ID #: ____

Group #: ______________________ Effective Date: ___________

Policy Holder: __________________ DOB: _____/_____/_____

SECONDARY INSURANCE

❑ Oregon Health Plan/ OHP/Medicaid
❑ Insurance through Employer or Private Policy

Company Name: ____

Policy ID #: ____

Group #: ______________________ Effective Date: ___________

Policy Holder: __________________ DOB: _____/_____/_____

PLEASE READ AND SIGN BELOW

Consent for Treatment: My signature below acknowledges that I, the patient or patient's legal representative, voluntarily request the healthcare practitioners and authorized personnel of Clackamas & Oregon Pediatrics to perform reasonable and necessary medical examinations, testing and treatment, including diagnostic and therapeutic procedures for the conditions(s) that bring me to seek care at this practice. I agree to permit laboratory tests, photographs for treatment and/or reporting purposes, routine medical treatment (such as medications, injections, immunizations & blood draws) and emergency procedures as necessary. Except in life threatening emergencies, when further treatment or procedures are recommended, I will be informed of the nature of the procedure, alternatives to and risks associates with treatment. I will have the opportunity to ask questions and receive answers, and additional consent may be required. I intend that this consent is continuing in nature and that it shall remain in effect until I revoke it in writing. I understand I have the right to discontinue services at any time.

Assignment of Benefits: My signature below acknowledges that in consideration of services received or to be received from healthcare practitioners and authorized personnel of Clackamas and Oregon Pediatrics I permit said personnel to bill all applicable insurance plans(s) for services received and assign all benefits for same to be paid directly to Clackamas & Oregon Pediatrics. I agree to pay for all services considered non-covered or ineligible. A photocopy of this Assignment shall be considered as effective and valid as the original.

Minors: My Signature below acknowledges my understanding that in most cases, patients less than 15 years of age must be accompanied by an authorized adult when seeking care at Clackamas & Oregon Pediatrics. Patients and legal representatives may authorize others to act on their behalf by completing an "Authorization of Delegate" form. Visits may need to be rescheduled until either of these conditions have been met.

Financial Policy: My signature below acknowledges I have received a copy of the Clackamas and Oregon Pediatrics Financial Policy and have read, understood and accepted its terms.

X______________________________________ ____________________________ _____/_____/_____

Signature of Parent / Legal Guardian **Relationship to Patient** **Date Signed**