

CLACKAMAS PEDIATRIC CLINIC
 9290 SE Sunnybrook Blvd., #200
 Clackamas, OR 97015-6777

OREGON PEDIATRICS - NE PORTLAND
 5050 NE Hoyt St., #523
 Portland, OR 97213-2984

OREGON PEDIATRICS - MERIDIAN PARK
 19260 SW 65th Ave., #275
 Tualatin, OR 97062-5708

Please complete the information below IN FULL

Patient Information	Last Name:		First Name:		MI	Sex M F	Date of Birth:	
	Address:				City:		State	Zip:
	Home Phone:			Message Phone:			SS #:	
	Primary Physician:			School Name (if applicable):		Referred by:		
Parent/Guarantor Information	Last Name:		First Name & MI:		Relationship to patient		Date of Birth:	
	Address (if different than child)			City:		State:	Zip	SS #:
	Home Phone:		Work Phone:		Employer:		ID / License #:	
	Last Name:		First Name & MI:		Relationship to patient		Date of Birth:	
	Address (if different than child)			City:		State:	Zip	SS #:
	Home Phone:		Work Phone:		Employer:		ID / License #:	
Emergency Contact	Emergency contact (other than parent)				Address:			
	Home Phone:			Other Phone:		Relation to child:		
Primary Insurance	Insurance Company:			ID #:		Group #:		
	Insurance Address:				Insurance Phone:		Coverage Effective Date:	
	Subscriber Name & Relationship to Patient (Father, Mother...)			Subscriber DOB:		Subscriber SS#		Copay (Out of Pocket):
Secondary Insurance	Insurance Company:			ID #:		Group #:		
	Insurance Address:				Insurance Phone:		Coverage Effective Date:	
	Subscriber Name & Relationship to Patient (Father, Mother...)			Subscriber DOB:		Subscriber SS#		Copay (Out of Pocket):

* The patient, parent &/or guardian are financially responsible for all services rendered, regardless of insurance. Co-payments and payment of all non-covered or disallowed charges is due at time of service. Copays not paid at time of service are subject to a billing fee. The subscriber is responsible to assure timely payment of applicable services by the insurance carrier within 90 days. Account balances over 90 days old, accounts sent to outside collections, and "No Show" appointments are all subject to additional charges.

* As a courtesy, this office bills *most* insurance carriers. Complete and current insurance information must be provided in order to do so. Please also provide a copy of you current insurance card.

* Your signature below constitutes you authorization for treatment, agreement of the payment terms, authorization for this office to bill the insurance carrier(s) with the information provided above, authorization to release medical data relating to a claim and authorization to assign benefits directly to the provider of service.

Signature

Relationship to patient

Date