Clackamas Oregon Pediatrics - PATIENT REGISTRATION FORM

PT LABEL

PATIENT / CHILD

Legal Name: ____________________ ❐ **Male** ❐ **Female**
(Last, First MI)

Date of Birth: __________ Preferred/Nickname: __________ SSN: __________

Address: ____________________
Street City State Zip

Primary Pharmacy (Name & location): ____________________

Primary Language: ❐ English ❐ Spanish ❐ Russian ❐ Hindi ❐ Vietnamese ❐ Other: __________

Ethnicity: ❐ Decline to state ❐ Hispanic or Latino ❐ Not Hispanic or Latino ❐ Unknown

Race: ❐ Decline to state ❐ American Indian/Alaska Native ❐ Asian ❐ Black/African American
❐ Other Race ❐ Native Hawaiian/Pac Islander ❐ Unknown ❐ White

CONTACT INFORMATION

Primary Phone: ____________________ ❐ Mom's cell or work ❐ Dad's cell or work
❐ Home ❐ Patient cell ❐ Other: __________

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

Other Phone: ____________________ ❐ Mom's cell or work ❐ Dad's cell or work
❐ Home ❐ Patient cell ❐ Other: __________

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

Primary eMail: ____________________, which belongs to ❐ Patient/Child ❐ Parent/Family

❐ *Check if you want to receive general information and updates from Clackamas & Oregon Pediatrics at this email?*

Other eMail: ____________________, which belongs to ❐ Patient/Child ❐ Parent/Family

❐ *Check if you want to receive general information and updates from Clackamas & Oregon Pediatrics at this email?*

PARENT / GUARDIAN / FINANCIAL RESPONSIBLE PERSON

Name: ____________________ DOB __________
(Last, First MI)

Relationship to child: ❐ Parent ❐ Step-Parent ❐ Foster ❐ Other: __________

❐ Male ❐ Female Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Partner ❐ Widowed

Do you have legal custody/authority of the patient? ❐ Yes ❐ No SSN: __________

Address, City, State, Zip (*if different than patient/child*): ____________________ Phone (if different than above): __________

Occupation & Employer: ____________________

OTHER PARENT / GUARDIAN

Name: ____________________ DOB __________
(Last, First MI)

Relationship to child: ❐ Parent ❐ Step-Parent ❐ Foster ❐ Other: __________

❐ Male ❐ Female Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Partner ❐ Widowed

Does this person have legal custody/authority of the patient? ❐ Yes ❐ No SSN: __________

Address, City, State, Zip (*if different than patient/child*): ____________________ Phone (if different than above): __________

Occupation & Employer: ____________________

Please continue on back

Patient/Child Name: DOB: EMR #:

SIBLINGS / Other children in the household

Name: ______	Name: ______
❒ M ❒ F DOB: ______	❒ M ❒ F DOB: ______
Name: ______	Name: ______
❒ M ❒ F DOB: ______	❒ M ❒ F DOB: ______
Name: ______	Name: ______
❒ M ❒ F DOB: ______	❒ M ❒ F DOB: ______

EMERGENCY CONTACT (other than household members)

Name: ______ Primary phone: ______

Relationship to patient/child: ______ Other phone: ______

BILLING / INSURANCE *(check all that apply)*

❒ No Insurance (Self Pay) ❒ Insurance through employer or private policy

❒ Oregon Health Plan/OHP/Medicaid *Which Plan:* ❒ CareOregon ❒ FamilyCare ❒ Providence ❒ Other

Primary Insurance Company Name:	Secondary Insurance Company Name:
Policy/ID #: ______	Policy/ID #: ______
Group #: ______	Group #: ______
Policyholder: ______ DOB: ______	Policyholder: ______ DOB: ______
Eff. Date: ______ Copay $: ______	Eff. Date: ______ Copay $: ______

PLEASE REVIEW & SIGN

Authorization 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 condition(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 associated with treatment. I will have 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 full 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 & Oregon Pediatrics I permit said personnel to bill all applicable insurance plan(s) for services received and assign all benefits for same to be paid directly to Clackamas & Oregon Pediatrics. I agree to pay for any and all services considered non-covered or ineligible. A photocopy of this Assignment shall be considered as effective and valid as the original.

Authorization to Release Information:

My signature below acknowledges that I permit Clackamas & Oregon Pediatrics and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and mental health treatment) to, including but not limited to, the appropriate healthcare insurer(s), attorney(s) and/or consultant(s) for purposes including treatment of the patient, billing or collecting payment for services and healthcare operations and/or as required by law. I permit Clackamas & Oregon Pediatrics and/or their authorized personnel to access electronic prescription data.

Minors:

My signature below indicates 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 has 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.

______ ______

Signature of patient/parent/guardian Date

Relationship to patient: ______