Clackamas Pediatric Clinic
8645 SE Sunnybrook Blvd #200
Clackamas, OR 97015
(503) 659-1694

Oregon Pediatrics – Meridian Park
19260 SW 65th Ave #275
Tualatin, OR 97062
(503) 691-2519

Oregon Pediatrics – Happy Valley
15970 SE Misty Dr. #100
Happy Valley, OR 97086
(503) 427-2637

Oregon Pediatrics – NE Portland
5050 NE Hoyt St. #B55
Portland, OR 97213
(503) 233-5393

Central Fax ● (503) 659-8984

Patient Accounts ● (503) 427-2118

PATIENT REGISTRATION:

CHILD NAME: _____ Nickname: _____
Last First MI

Date of Birth: _____ ❑ Male ❑ Female SSN: _____

Address: _____
Street City State Zip

Primary Phone: (_____) _____ ❑ Home ❑ Mom Cell ❑ Dad Cell ❑ Patient Cell
❑ **OK TO TEXT APPOINTMENT REMINDERS TO THIS NUMBER**

Preferred Provider: _____ Preferred Location: _____

Primary Language: _____

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

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

PARENT / GUARDIAN / FINANCIALLY RESPONSIBLE

PRIMARY GUARDIAN: _____ Nickname: _____
Last First MI

Date of Birth: _____ ❑ Male ❑ Female SSN: _____

Address: ❑ **Same as Patient** _____
Street City State Zip

Primary Phone: (_____) _____ ❑ Home ❑ Cell
Do we have your permission to leave a detailed and/or confidential voice message at this number? ❑ Yes ❑ No

Email: _____, which belongs to: ❑ Patient/Child ❑ Parent/Family
❑ **I would like to access my child's records online via My Health** _____ **PLEASE INITIAL**

Do you have Legal custody/authority of the Patient? ❑ Yes ❑ No

Relationship to Child: ❑ Parent ❑ Step-Parent ❑ Foster ❑ Other: _____

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

Occupation & Employer: _____ Employer Phone: (_____) _____

SECONDARY GUARDIAN: _____ Nickname: _____
Last First MI

Date of Birth: _____ ❑ Male ❑ Female SSN: _____

Address: ❑ **Same as Patient** _____
Street City State Zip

Primary Phone: (_____) _____ ❑ Home ❑ Cell
Do we have your permission to leave a detailed and/or confidential voice message at this number? ❑ Yes ❑ No

Email: _____, which belongs to: ❑ Patient/Child ❑ Parent/Family
❑ I would like to access my child's records online via My Health _____ **PLEASE INITIAL**

Do you have Legal custody/authority of the Patient? ❑ Yes ❑ No

Relationship to Child: ❑ Parent ❑ Step-Parent ❑ Foster ❑ Other: _____

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

Occupation & Employer: _____ Employer Phone: (_____) _____

** PLEASE CONTINUE ON BACK **

Patient Name: _____ Patient DOB: _____

EMERGENCY CONTACT INFORMATION (*OTHER THAN GUARDIAN)*

EMERGENCY CONTACT NAME: _____ Primary Phone: (_____) _____

Relationship to Patient: _____ Other Phone: (_____) _____

❑ Ok to schedule, confirm, and cancel appointments and accompany my child to visits at CPC/OP and in general act on my behalf during the visit to authorize treatment, including but not limited to vaccinations and/or procedures for my child.
***Please see staff for our Authorization of Delegate form for long term authorization.**

SIBLINGS / OTHER CHILDREN IN THE HOUSEHOLD

Sibling Name: _____
❑ Male ❑ Female Date of Birth: _____

Sibling Name: _____
❑ Male ❑ Female Date of Birth: _____

Sibling Name: _____
❑ Male ❑ Female Date of Birth: _____

Sibling Name: _____
❑ Male ❑ Female Date of Birth: _____

BILLING AND INSURANCE *(CHECK ALL THAT APPLY)*

❑ No Insurance (Self Pay)

PRIMARY INS.

❑ Oregon Health Plan/ OHP/Medicaid

❑ Insurance through Employer or Private Policy

Company Name: _____

Policy ID #: _____ Group #:_____

Policy Holder: _____ DOB: _____

Effective Date:_____ Co-Pay $: _____

SECONDARY INS.

❑ Oregon Health Plan/ OHP/Medicaid

❑ Insurance through Employer or Private Policy

Company Name: _____

Policy ID #: _____ Group #:_____

Policy Holder: _____ DOB: _____

Effective Date:_____ Co-Pay $: _____

PLEASE REVIEW, READ & 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 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.

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 of 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 pediatric and/or their authorized personnel to access electronic prescription data.

Minors:
My Signature below acknowledges my understanding that in most cases, patients less than 15 years of age must be accompanied by and 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: _____