evergreen pediatric clinic

Patient Registration Form

Primary Parent/Guardian: *Please list parents/guardians separately regardless of marital or custodial status*

Name _____ SSN# _____ Date of Birth _____
☐MALE ☐FEMALE MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other

Primary Language _____ Interpreter Needed? ☐YES ☐ NO

Country of origin _____ Religion _____

Address _____ City _____ State _____ Zip _____

Cell #: _____ Home #: _____ Email _____

Work #: _____ Employer: _____

Secondary Parent/Guardian:

Name _____ SSN# _____ Date of Birth _____
☐MALE ☐FEMALE MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other

Primary Language _____ Interpreter Needed? ☐YES ☐ NO

Country of origin _____ Religion _____

Address _____ City _____ State _____ Zip _____

Cell #: _____ Home # _____ Email _____

Work #: _____ Employer: _____

Other Parent/Guardians/Emergency Contacts:

Name _____ Cell Phone _____

Relationship to patient(s) _____ ☐ Foster Parent ☐ Other _____

Patient(s) Information:

1.) NAME: _____ BIRTHDATE: _____ ☐MALE ☐FEMALE
(Last) (First) (M.I.)

SSN: _____ Relationship to Patient _____ New Patient: ☐YES ☐ NO

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Other _____
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

2.) NAME: _____ BIRTHDATE: _____ ☐MALE ☐FEMALE
(Last) (First) (M.I.)

SSN: _____ Relationship to Patient _____ New Patient: ☐YES ☐ NO

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Other _____
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

3.) NAME: _____ BIRTHDATE: _____ ☐MALE ☐FEMALE
(Last) (First) (M.I.)

SSN:_____ Relationship to Patient _____ New Patient: ☐YES ☐ NO

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Other_____
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

4.) NAME: _____ BIRTHDATE: _____ ☐MALE ☐FEMALE
(Last) (First) (M.I.)

SSN:_____ Relationship to Patient _____ New Patient: ☐YES ☐ NO

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Other_____
Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino

5.) NAME: _____ BIRTHDATE: _____ ☐MALE ☐FEMALE
(Last) (First) (M.I.)

SSN:_____ Relationship to Patient _____ New Patient: ☐YES ☐ NO

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Other_____
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

BILLING INFORMATION

☐PRIVATE PAY (NO INSURANCE) ☐DSHS / ☐Molina Healthcare

☐INSURANCE (PRIMARY) EFF. DATE:_____ ☐INSURANCE (SECONDARY) EFF. DATE:_____

INSURANCE CO._____ INSURANCE CO._____

POLICY HOLDER _____ D.O.B. _____ POLICY HOLDER _____ D.O.B. _____

MEMBER NUMBER:_____ MEMBER NUMBER:_____

GROUP NUMBER: _____ GROUP NUMBER: _____

Who referred you to our office?

_____

CONSENT FOR TREATMENT: I hereby consent to and authorize the examining physician and any assistants or associates to conduct such physical examinations and perform such tests and treatment as the examining physician deems necessary and appropriate. I also authorize personnel of the clinic to provide routine services requested by the physician. Should treatment be performed, the physician will fully inform me as to the nature of the procedure, the alternatives to treatment, and the risks that are involved and that I will be given the opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand the examining physician will discuss this with me and that an additional consent(s) by me may be required.

FINANCIAL RESPONSIBILITY: For and in consideration of the treatment to the patient, I promise to pay all charges for services rendered to or on behalf of the patient. If the assigned insurance denies payment, I promise to pay the balance due upon notification. Any unpaid balance that is over 60 days old will be referred to Collections for accounts receivable assistance. I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

RELEASE OF INFORMATION: I authorize Evergreen Pediatric Clinic to release any information necessary to process the claim.

ASSIGNMENT OF BENEFITS: I authorize my insurance/benefits carrier(s) to remit payment of benefits for any claim to Evergreen Pediatric Clinic. I understand that any ineligible/not covered charges are my responsibility.

PRIVACY POLICY: I have received a copy of the current Privacy Notice of Evergreen Pediatric Clinic.

SIGNATURE: _____ **PRINT NAME**: _____ **DATE**: _____