willamette falls pediatric group

1510 Division Street, Suite 280, Oregon City, OR 97045
T 503.905.3400 • F 503.905.3399

200 Hazel Dell Way, Suite 202, Canby, OR 97013
T 503.266.8500 • F 503.266.8585

PATIENT REGISTRATION

PATIENT'S NAME Last _____ First _____ Middle _____

Birth Date ___/___/_____ Sex ❑ M ❑ F SSN ___ - ___ - _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone (___) _____ - _____ Email _____

Patient's Primary Care Physician (PCP) _____

Who referred you to Willamette Falls Pediatric Group? ❑ Friend/Relative ❑ Dr/Provider ❑ Advertisment ❑ Other

Referer's Name _____

Siblings: Last _____ First _____ Middle _____ Birth Date ___/___/_____

Last _____ First _____ Middle _____ Birth Date ___/___/_____

Last _____ First _____ Middle _____ Birth Date ___/___/_____

Last _____ First _____ Middle _____ Birth Date ___/___/_____

PATIENT'S PARENTS OR GUARDIAN INFORMATION

PRIMARY GUARDIAN _____ ___/___/_____ ___ - ___ - _____
Last Name First Middle Birth Date Social Security Number

Address ❑ Same as Patient _____ Apt # _____

City _____ State _____ Zip _____ Home Phone (___) _____

Employer _____ Work Phone (___) _____ Cell Phone (___) _____

SECONDARY GUARDIAN _____ ___/___/_____ ___ - ___ - _____
Last Name First Middle Birth Date Social Security Number

Address ❑ Same as Patient _____ Apt # _____

City _____ State _____ Zip _____ Home Phone (___) _____

Employer _____ Work Phone (___) _____ Cell Phone (___) _____

EMERGENCY CONTACT INFORMATION (Other Than Listed Above)

Name _____ Relationship To Patient _____

Home Phone (___) _____ Work or Cell Phone (___) _____

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE COMANY

Name _____ Subscriber _____

Subscriber Birth Date ___/___/_____ Relationship to Patient _____ Effective Date ___/___/_____

SS or ID # _____ Group # _____ Co-Pay Fee (if any) $ _____

SECONDARY INSURANCE COMANY

Name _____ Subscriber _____

Subscriber Birth Date ___/___/_____ Relationship to Patient _____ Effective Date ___/___/_____

SS or ID # _____ Group # _____ Co-Pay Fee (if any) $ _____

I hereby authorize Willamette Falls Pediatric Group to provide medical services to the above named patient and to use and release medical information as required for treatment, payment and health care operations. I also assign Willamette Falls Pediatric Group all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of visit will result in additional charges. I have received a copy of the current Privacy Notice of Willamette Falls Pediatric Group.

Signature _____ Date _____