Snake River PEDIATRICS

Infants, Children, & Adolescents

PATIENT REGISTRATION

Today's Date____/____/_____

PATIENT _____ DOB _____ Sex: Male or Female
Address _____ Home Phone _____
City/State/Zip _____ Cell Phone _____

PARENT #1 _____ DOB_____ SS#_____
Address _____ Primary Phone _____
City/State/Zip _____ Cell Phone _____
Employer/Occupation _____ Day Phone _____
Employer Address _____ Email _____
Relationship– Circle One: Mother, Father I Stepmom, Stepdad I Foster Parent I Grandparent I Relative

PARENT #2 _____ DOB_____ SS#_____
Address _____ Primary Phone _____
City/State/Zip _____ Cell Phone _____
Employer/Occupation _____ Day Phone _____
Employer Address _____ Email _____
Relationship – Circle One: Mother, Father I Stepmom, Stepdad I Foster Parent I Grandparent I Relative

Parents are (circle one): Married |Living Together |Separated |Divorced If divorced, who is the custodial parent: #1 | #2

Sibling _____DOB _____ M or F Sibling _____DOB _____ M or F
Sibling _____DOB _____ M or F Sibling _____DOB _____ M or F
Sibling _____DOB _____ M or F Sibling _____DOB _____ M or F

Emergency Contact _____Home # _____Mobile # _____

Consent to treat

I give my permission for the following listed people to bring my child to Snake River Pediatrics, PC to obtain medical care in my absence. I understand that by signing this form I am authorizing them to treat my child as long as I seek care from Snake River Pediatrics providers or until I withdraw my consent.

Name _____Phone # _____ Name _____ Phone # _____

Immunization Consent

I give my permission for the following people to bring my child in for immunizations in my absence.

Name _____Phone # _____ Name _____ Phone # _____

Insurance Information (please provide us with a copy of your most recent card)

Insurance Carrier _____ **ID #** _____ **Eff Date** _____
Co-Pay $ _____Name of Insured _____ Group ID _____
Insurance provided through (circle one): Employer | Private | Other | Self Pay | Oregon Medicaid | Idaho Medicaid
Provider you prefer to see _____
Preferred Pharmacy _____ **Location** _____

Authorization of Treatment and Assignment of Benefits:

I authorize Snake River Pediatrics, PC to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to Snake River Pediatrics, PC for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Snake River Pediatrics, PC for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits.** I also understand that I am responsible for advising Snake River Pediatrics, PC for any and all changes to my insurance. **Payment of co-pays are due on the date of service per the contract with your insurance carrier.**

Signature _____ Relationship _____

A photocopy or scan of this authorization shall be considered effective and valid as the original.