

East Portland Pediatric Clinic, P.C., Physicians
10,000 S.E. Main Street, Suite 30
Portland, OR 97216
503-255-3544 - Fax 503-251-6827

Referred to Us By: _____

Home Address _____ Apt # _____

City _____ State _____ Zip Code _____

Please **list & identify** the two best phone numbers to contact you.

Primary Phone # _____	home, work, cell, other (Please Circle)	Secondary Phone # _____	home, work, cell, other (Please Circle)
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Mother _____ DOB ____ - ____ - ____ SS# ____ - ____ - ____

Address Same as patient _____ Phone # _____

Employer _____ Phone # _____ Occupation _____

Father _____ DOB ____ - ____ - ____ SS# ____ - ____ - ____

Address Same as patient _____ Phone # _____

Employer _____ Phone # _____ Occupation _____

Please List all children's names (first & last) who are or will be seen at our clinic

Name of Child seen today _____ M / F DOB ____ - ____ - ____ Doctor _____

Name _____ M / F DOB ____ - ____ - ____ Doctor _____

Name _____ M / F DOB ____ - ____ - ____ Doctor _____

Name _____ M / F DOB ____ - ____ - ____ Doctor _____

Name _____ M / F DOB ____ - ____ - ____ Doctor _____

Person not living at your address to contact in case of an emergency

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

****We will be glad to bill your insurance upon receipt of copy of your insurance card within 30 days of appointment****

INSURANCE INFORMATION

Primary Insurance

Insurance Co. _____ Subscriber _____ Sub. DOB ____ - ____ - ____

Secondary Insurance

Insurance Co. _____ Subscriber _____ Sub. DOB ____ - ____ - ____

I hereby authorize East Portland Pediatric Clinic, P.C. to release any medical information necessary to process claims with any insurance companies. I also assign East Portland Pediatric Clinic, P.C. 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 my insurance or not. I hereby authorize the doctors of East Portland Pediatric Clinic, P.C. to provide such medical services, either regular or emergency, as may be determined to be in the best interest of those members of my immediate family, as listed above, who are minors. This authorization shall continue and be in full force and effect until revoked in writing by me.

Signature of Parent / Guardian _____ **Date** _____

Relationship to Patient: _____

For Office Use Only:

NP/NF _____ NP/OF _____ UPDATE ONLY _____

Information Entered By: _____ Date: _____

New Patient Talk With _____

Done By: _____ Date: _____