

# Welcome to Hillsboro Pediatric Clinic LLC

## PATIENT ADDRESS CHANGE FORM



Thank you for selecting us for your child's healthcare provider!  
In order to serve you, we need the following information. **Please print.**

**Please list all children who are patients of Hillsboro Pediatric Clinic and affected by address change**

PATIENT INFORMATION (INCLUDE SIBLINGS SEEN IN CLINIC)				
Last Name:	First:	Middle:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:
Last Name:	First:	Middle:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:
Last Name:	First:	Middle:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:
Last Name:	First:	Middle:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:
Last Name:	First:	Middle:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:
ADDRESS WHERE PATIENT(S) RESIDE				
Street Address:	Apt. #:	City/Town:	State:	Zip Code:
Resides with: : <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Parents <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other:				
PARENT INFORMATION				
Relationship to Patient: : <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other:				
Last Name:	First Name:	Middle:	Birthdate:	
Mailing Address:	Apt. #:	City/Town:	State:	Zip Code:
Street Address: <input type="checkbox"/> Same as above	Apt. #:	City/Town:	State:	Zip Code:
Employer:	Social Security Number:		Email Address:	
	Preferred Language:		Need interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OTHER PARENT INFORMATION				
Relationship to Patient: : <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other:				
Last Name:	First Name:	Middle:	Birthdate:	
Mailing Address: <input type="checkbox"/> Same as above	Apt. #:	City/Town:	State:	Zip Code:
Street Address: <input type="checkbox"/> Same as above	Apt. #:	City/Town:	State:	Zip Code:
Employer:	Social Security Number:		Email Address:	
CONTACT METHOD				
Phone 1:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Cell Mom <input type="checkbox"/> Cell Dad	Phone 2:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Cell Mom <input type="checkbox"/> Cell Dad	
Phone 3:	<input type="checkbox"/> Cell Mom <input type="checkbox"/> Cell Dad <input type="checkbox"/> Work Mom <input type="checkbox"/> Work Dad	Phone 4:	<input type="checkbox"/> Work Mom <input type="checkbox"/> Work Dad <input type="checkbox"/> Other _____	
EMERGENCY CONTACT OR DHS CASEWORKER				
First and Last Name:		Relationship to Patient:		
Primary Telephone Number:		Secondary Telephone Number:		

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

Hillsboro Pediatric Clinic LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-503-640-2757.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-503-640-2757.