PATIENT REGISTRATION FORM

Thank you for selecting us for your child's healthcare provider! In order to serve you, we need the following information. Please **NOTE**: If Legal Guardian is checked below, we assume this person has full legal guardianship status unless otherwise stated. **Please print**.

PATIENT INFORMATION			
Legal Last Name:	Legal First:	Middle:	Birth Date:
Preferred Name:		Pronouns:	Sex at birth: ☐ Male ☐ Female
Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White, not Hispanic ☐ Black or African American ☐ Hispanic ☐ Decline to Answer			

ADDRESS WHERE PATIENT LIVES				
Street Address:	Apt. #:	City/Town:	State:	Zip Code:
Resides with: (check all that apply) ☐ Legal Guardian ☐ Mother ☐ Father ☐ Resource Parent ☐ Other:				

CONTACT INFORMATION				
Relationship to Patient: (check all that apply) ☐ Legal Guardian ☐ Mother ☐ Father ☐ Resource Parent ☐ DHS ☐ Other:				
Last Name:	First Name:	Middle:	Birthdate:	
Mailing Address:	Apt. #:	City/Town:	State:	Zip Code:
Street Address: ☐ Same as above	Apt. #:	City/Town:	State:	Zip Code:
Employer:	Social Security Number:	Email Address (1):		
	Preferred Language:	Need interpreter? ☐ Yes ☐ No		

OTHER CONTACT INFORMATION				
Relationship to Patient: (check all that apply) ☐ Legal Guardian ☐ Mother ☐ Father ☐ Resource Parent ☐ DHS ☐ Other:				
Last Name:	First Name:	Middle:	Birthdate:	
Mailing Address: ☐ Same as above	Apt.#:	City/Town:	State:	Zip Code:
Employer:	Social Security Number:	Email Address (2):		

CONTACT METHOD				
Phone 1:	☐ Home ☐ Cell ☐ Cell Mom ☐ Cell Dad	Phone 2:	☐ Home ☐ Cell ☐ Cell Mom ☐ Cell Dad	
Phone 3:	☐ Cell Mom ☐ Cell Dad ☐ Work Mom ☐ Work Dad	Phone 4:	☐ Work Mom ☐ Work Dad ☐ Other	

BILLING INFORMATION	
☐ Self-Pay (No Insurance)	OHP: ☐ OHSU Health Services ☐ Care Oregon ☐ Yamhill Coordinated Care ☐ DMAP **Client ID #:** _____
☐ INSURANCE (Primary) Effective Date: ____/____/____ Insurance Name: _____ Subscriber Name: _____ DOB: ____/____/____ Policy #: _____ Group #: _____ Copay: $ _____	☐ INSURANCE (Secondary) Effective Date: ____/____/____ Insurance Name: _____ Subscriber Name: _____ DOB: ____/____/____ Policy #: _____ Group #:_____ Copay: $ _____

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.

HPC REG CONSENTS Hillsboro Pediatric Clinic LLC

PATIENT INFORMATION			
Legal Last Name:	Legal First:	Middle:	Birth Date:

THE FOLLOWING CONSENTS AND PERMISSIONS APPLY TO ME AND MY CHILD

Pharmacy: I hereby authorize Hillsboro Pediatric Clinic LLC (HPC) to electronically send prescriptions to a participating pharmacy of my choice. HPC may electronically receive information regarding my and/or my child's prescription history, drug interactions, prior authorization requirements or required substitutions.

Pharmacy Name: _____ **Location:** _____

Contact Preferences: I would prefer that HPC use the preferred contact method indicated below when confirming appointments:

☐ Phone ☐ Email ☐ Text

Patient Centered Primary Care Home: As a Patient Centered Primary Care Home ("Medical Home") HPC is committed to providing the highest quality patient centered care. HPC care is delivered by a team of health care professionals including Physicians and Nurse Practitioners, Registered Nurses, Medical Assistants and other skilled staff. I will be encouraged and supported as I am involved in my and/or my child's care. The goal is to ensure that my and/or my child's healthcare needs are coordinated for the best possible health outcome. For more details I recognize that I have access to a Medical Home Brochure.

Authorization to Treat: By my signature below I give permission to HPC to treat me and/or my child. By signing this form, I am consenting to the Clinic's use and disclosure of my protected health information to carry out treatment, payment or healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hillsboro Pediatric Clinic LLC may decline to provide treatment to the patient listed above.

I ATTEST TO THE ABOVE:

Patient or Legal Guardian Name: _____ **Relationship to patient:** _____

Signature: _____ **Date:** _____

Notice of Privacy Practices: I also acknowledge that I have access to a complete copy of HPC's Notice of Privacy Practices, which describes in detail how medical information about me and/or my child may be used and disclosed, and how I can get access to this information.

I ATTEST TO THE ABOVE:

Signature: _____ **Date:** _____

☐ Patient or responsible party refused to sign the acknowledgement. _____ _____

CANCELLATION/NO SHOW POLICY Hillsboro Pediatric Clinic LLC

PATIENT INFORMATION			
Last Name:	Legal First:	Middle:	Birth Date:

Hillsboro Pediatric Clinic (HPC), its providers and staff, are committed to providing your child - and all of our patients - with exceptional care. When you chose HPC, you made us a partner in your child's healthcare. To be a productive partner, we need to carefully manage our time to make ourselves available to our patients as we are needed. In order to achieve this, we must make sure that our patients fulfill their appointment commitments.

We understand that sometimes things happen that prevent us from doing what we had planned. When a patient's plan changes and they cancel without giving us enough notice, we cannot use that appointment for another patient to be seen. We put the following policies into place for this reason.

General Cancelling/Rescheduling Guidelines:
Call us at 503-640-2757 at least 24 hours before your scheduled appointment to notify tell us of any changes or cancellations. Failure to give at least one hours' notice of rescheduling or cancelling an appointment will be considered a no show appointment.

- **Cancelled Appointment:** Call the clinic with **more than 24 hours' notice** of scheduled appointment. (*For Example: To cancel a Monday appointment, please call our office by Saturday at 11:00 am.)*
- **Late Cancellation:** Call the clinic to cancel or reschedule the appointment with **less than 24 hours' notice**. (Late cancellation will still apply even if the appointment is rescheduled for same day or next day)
- **No Show:** Not coming to a scheduled appointment or calling less than an hour before the appointment to cancel or reschedule.

Warning Letters:
First and Second warning letters will be mailed when all the children in the family have a combined total of 2 and 3 No Shows, or 3 and 4 Late Cancellation appointments.

NOTE: Evening appointments are usually reserved for sick or injury visits; however, there are times when we are able to schedule limited routine visits in the evenings. There are not enough routine evening appointments for everyone who wants one. If your child is scheduled for a routine visit in the evening and No Shows, your child(ren) may not be able to have routine visits in the evening in the future. If this happens, we will tell you. Your child(ren) will still be able to have appointments for sick or injury visits in the evening.

Termination of Care Letter:
If No show or late cancellation behavior continues after the warning letters, you may be asked to find a new primary care provider.

Please feel free to call us at any time if there are problems that make it difficult for you to keep your child's appointments. Our Care Coordinators may be able to direct you to resources that can help.

Thank you for partnering with us!

_____
Responsible Party Full Name

_____ _____
Signature of Parent/Legal Guardian Date

Child's Name: _____ **Date of Birth:** _____

Patient History

Please answer the following questions about your baby's/child's medical and family history.
The physician may ask further details about "yes" answers.

PREGNANCY AND BIRTH:

	YES	NO
Where there any problems with pregnancy or delivery of this child?	☐	☐

If yes, please explain:_____

Was Baby full Term ☐ or Early? ☐ If early, how many weeks?_____

Was your child breastfed? ☐ YES ☐ NO If so, for how long? _____

Type of Delivery: Vaginal ☐ C-section ☐ Length _____ Weight _____

Problems:	Yes	No		Yes	No
Jaundice	☐	☐	Breech	☐	☐
Respiratory Distress	☐	☐	Developmental Problems	☐	☐
Feeding Problems	☐	☐	If yes, please explain:		
Rash	☐	☐			

HOSPITALIZATIONS/OPERATIONS:

☐ NONE

Hospital	Reason	Year

MEDICATIONS AND DOSAGES (Please include over the counter, supplements, homeopathic and prescribed medications):

☐ NONE

ALLERGIES TO ANY MEDICATIONS? (Please list)

☐ NONE KNOWN

DOES YOUR CHILD SEE ANY SPECIALISTS? (Nutritionist; Occupational, Physical and/or Speech Therapist; Counselor; or other medical specialists)

☐ NONE

Name of Specialist	Reason

SOCIAL AND ENVIRONMENTAL HISTORY

	Yes	No
How many hours of exercise does your child get per day? _____		
Does your child spend more than 2 hours per day watching TV, playing video games, or on the computer?	☐	☐
Does anyone living in the home smoke?	☐	☐
Does anyone living in the home drink alcohol?	☐	☐
Are there smoke detectors in the home?	☐	☐
Seat belts used in your car?	☐	☐
Is your child in school or day care?	☐	☐
Does your child wear a bike helmet while riding?	☐	☐
Are there guns in your home?	☐	☐
Do you have the poison-control center phone number near your telephone?	☐	☐

Medical History (Check if your baby/child has had any of the following):

Asthma	☐	Epilepsy	☐
Anemia	☐	Eye or vision problems	☐
Chicken Pox	☐	Kidney/Bladder problems	☐
Diabetes	☐	Liver disease/Jaundice	☐
Chronic diarrhea/constipation	☐	Tuberculosis	☐
Ear problems	☐	Other (Please explain)	☐
Eczema (overly dry skin)	☐	_____	

Child's Name: _____ **Date of Birth:** _____

Please List Patient's Biological Parents:

Mother: _____ DOB: _____

Father: _____ DOB: _____

Does Patient live with Biological Parents? (Check one) YES ☐ NO☐

If No, please indicate name of person patient is living with and relationship below:

Name: _____ **Relationship to Patient:** _____

FAMILY MEDICAL HISTORY (Please fill out the following based only on biological family members of the patient)

☐ CHECK HERE IF NONE OF THE CONDITIONS BELOW APPLY TO ANY BIOLOGICAL FAMILY MEMBERS

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent	Other
ADD/ADHD	☐	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	
Birth Defects	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	
Heart Problems	☐	☐	☐	☐	☐	
Hip Problems	☐	☐	☐	☐	☐	
Deafness	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	
Developmental Delay	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	
Eczema	☐	☐	☐	☐	☐	
Genetic Disorder	☐	☐	☐	☐	☐	
Blood Disorder	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	
Learning Disability	☐	☐	☐	☐	☐	
Intellectual Disability	☐	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	☐	
Obesity	☐	☐	☐	☐	☐	
Curved Spine	☐	☐	☐	☐	☐	
Seizure Disorder	☐	☐	☐	☐	☐	
Sudden Infant Death	☐	☐	☐	☐	☐	
Crossed Eyes	☐	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

Signature **Print Name** **Relationship to Patient** **Date**