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 ☐ Asian ☐ Black or African American ☐ Decline to Answer
☐ Native Hawaiian or Other Pacific Islander ☐ White, not Hispanic ☐ Hispanic

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

How did you hear about us?

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 ☐ CareOregon ☐ 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.