Eugene Pediatric
ASSOCIATES
995 Willagillespie Road, Suite 100, Eugene, Oregon 97401
Phone: (541) 484-5437 Fax: (541) 343-7360 or (541) 484-0155

Patient Contacts

Contact #1: _____ Date of Birth: _____ Male ☐ Female ☐
Last First Middle

Relationship to Patient: Mother ☐ Father ☐ Step-Parent ☐ Grandparent ☐ Guarantor ☐ Other:_____

Street Address:_____ **Home Phone**:_____

City: _____ State:_____ Zip:_____ **Cell Phone**: _____

Employer: _____ Occupation: _____Work Phone: _____

☐ **It is okay to contact this person on my behalf for appointment reminders and lab results.**
☐ **This contact has permission to seek medical treatment on my behalf.**

Contact #2: _____ Date of Birth: _____ Male ☐ Female ☐
Last First Middle

Relationship to Patient: Mother ☐ Father ☐ Step-Parent ☐ Grandparent ☐ Guarantor ☐ Other:_____

Street Address:_____ **Home Phone**:_____

City: _____ State:_____ Zip:_____ **Cell Phone**: _____

Employer: _____ Occupation: _____Work Phone: _____

☐ **It is okay to contact this person on my behalf for appointment reminders and lab results.**
☐ **This contact has permission to seek medical treatment on my behalf.**

Contact #3: _____ Date of Birth: _____ Male ☐ Female ☐
Last First Middle

Relationship to Patient: Mother ☐ Father ☐ Step-Parent ☐ Grandparent ☐ Guarantor ☐ Other:_____

Street Address:_____ **Home Phone**:_____

City: _____ State:_____ Zip:_____ **Cell Phone**: _____

Employer: _____ Occupation: _____Work Phone: _____

☐ **It is okay to contact this person on my behalf for appointment reminders and lab results.**
☐ **This contact has permission to seek medical treatment on my behalf.**

Contact#4: _____ Date of Birth: _____ Male ☐ Female ☐
Last First Middle

Relationship to Patient: Mother ☐ Father ☐ Step-Parent ☐ Grandparent ☐ Guarantor ☐ Other:_____

Street Address:_____ **Home Phone**:_____

City: _____ State:_____ Zip:_____ **Cell Phone**: _____

Employer: _____ Occupation: _____Work Phone: _____

☐ **It is okay to contact this person on my behalf for appointment reminders and lab results.**
☐ **This contact has permission to seek medical treatment on my behalf.**

Patient/Parent Signature Date