Eugene Pediatric ASSOCIATES

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Adolescent Patient Registration Form (13-17 years)

Note: Only one Guarantor per patient (who is financially responsible?)

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

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

Marital Status: M ☐ S ☐ D ☐ W ☐ SS#: _____ **Email:** _____

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

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

Employer: _____ Occupation: _____ Work Phone: _____(

(Patient, please initial all that apply)

I give Eugene Pediatric Associates, LLC permission to share the following: *( )STD Screenings ( )Pregnancy Tests ( )Mental Health ( )HIV/AIDS*

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

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

Marital Status: M ☐ S ☐ D ☐ W ☐ SS#: _____ **Email:** _____

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

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

Employer: _____ Occupation: _____ Work Phone_____

(Patient, please initial all that apply)

I give Eugene Pediatric Associates, LLC permission to share the following: *( )STD Screenings ( )Pregnancy Tests ( )Mental Health ( )HIV/AIDS*

Patient: _____ **Date of Birth:** _____ **Sex: M ☐ F ☐ Age:** _____
Last **First** **Middle**

Cell Phone # _____ **Lives with: ☐ Father ☐ Mother ☐ Both ☐ Other:** _____

Email Address (unique, cannot be used for another patient): _____

Race (Please circle one) Hispanic - Asian - Caucasian - African American - American Indian - Alaska Native
Pacific Islander - Filipino - Other: _____

Primary Language (please circle one) English – Spanish – French – Italian – German – Mandarin – other _____

Ethnicity (Please circle one) Hispanic or Latino - NonHispanic or Latino - Other or Undetermined

Primary Insurance: _____ ID# _____ Group #: _____
Subscriber: ☐ Father ☐ Mother ☐ Other: _____

Secondary Insurance: _____ ID# _____ Group #: _____
Subscriber: ☐ Father ☐ Mother ☐ Other: _____

(Patient, please initial to show understanding of the OMNIBUS Rule)

( ) Under the OMNIBUS Rule 2013, if I wish to keep this visit private from all parties (Parent/Guardian and inusrance carriers) I will notify the front desk at checkin. I understand in doing so, I will need to pay for this visit, labs, referrals and followup visits in full at the end of today's visit. Failure to do so, will invalidate the OMNIBUS Rule.

_____
Patient Signature: **Date:**

Other than parents, I authorize the following people to obtain medical treatment for my child(ren):

_____
Name Relationship to Patient Phone

_____
Parent/Guardian Signature: **Date:**