Eugene Pediatric ASSOCIATES

995 Willagillespie Road, Suite 100, Eugene, Oregon 97401
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Patient Registration Form (18 and Older)

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

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

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

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

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 ☐ Self ☐ Spouse ☐ Other: _____

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

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: _____

☐ **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.**
☐ **I give Eugene Pediatric Associates, LLC permission of 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 _____

☐ **It is okay to contact this person on my behalf for appointment reminders and lab results.**
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Please check the following, if it applies:

( ) 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.

In case of emergency, who should be notified?

Name: _____ ***Relationship to patient:*** _____ ***Phone:*** _____

_____

Patient Signature ***Date:***