Eugene Pediatric ASSOCIATES

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

Patient Registration Form (Minor Under Age 13)

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

DATE: _____

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: _____

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 _____

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

Lives with: ☐ Father ☐ Mother ☐ Both ☐ Other: _____

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

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

Lives with: ☐ Father ☐ Mother ☐ Both ☐ Other: _____

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: _____

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

_____
Name Relationship to Patient Phone