

Metropolitan Pediatrics

Patient Information Form



Clackamas
9300 SE 91st Ave., Ste. 200
Happy Valley, OR 97086
503.261.1171

Gresham
24988 SE Stark St., Ste. 200
Gresham, OR 97030
503.667.8878

Northwest
1130 NW 22nd Ave., Ste. 320
Portland, OR 97210
503.295.2546

Westside
1960 NW 167th Pl., Ste. 100
Beaverton, OR 97006
503.531.3434

PARENT INFORMATION	PATIENT INFORMATION
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Name: _____
(Last) (First) (MI)

SSN: _____ DOB: ___/___/___ Male Female

Marital Status: Married Single Divorced Widowed

Address: _____
(Street)

(City) (State) (Zip)

e-mail: _____

Home Ph: (____)____-____ Work Ph: (____)____-____

Employer: _____

Name: _____
(Last) (First) (MI)

DOB: ___/___/___ New Patient? Y N

SSN: _____ Male Female

OTHER PARENT INFORMATION

Name: _____
(Last) (First) (MI)

SSN: _____ DOB: ___/___/___ Male Female

Marital Status: Married Single Divorced Widowed

Address: _____
(Street)

(City) (State) (Zip)

e-mail: _____

Home Ph: (____)____-____ Work Ph: (____)____-____

Employer: _____

OTHER CHILDREN IN FAMILY

Name: _____
(Last) (First) (MI)

DOB: ___/___/___ Seen here? Y N

SSN: _____ Male Female

Name: _____
(Last) (First) (MI)

DOB: ___/___/___ Seen here? Y N

SSN: _____ Male Female

Name: _____
(Last) (First) (MI)

DOB: ___/___/___ Seen here? Y N

SSN: _____ Male Female

EMERGENCY CONTACT (other than spouse)

Name: _____
(Last) (First) (MI)

Relationship to Patient: _____

Home Ph: (____)____-____ Work Ph: (____)____-____

BILLING INFORMATION

PRIVATE PAY (No Insurance)

INSURANCE (Primary) Eff. Date: ___/___/___

Insurance Co: _____

Employer: _____

Policyholder: _____ DOB: ___/___/___

Policy #: _____

Group #: _____ Copay Amount \$ _____

OHP Family Care / OMAP (circle one)

INSURANCE (Secondary) Eff. Date: ___/___/___

Insurance Co: _____

Employer: _____

Policyholder: _____ DOB: ___/___/___

Policy #: _____

Group #: _____ Copay Amount \$ _____

CONSENT FOR TREATMENT: I authorize the physicians and clinic personnel of Metropolitan Pediatrics, LLC, to conduct physical examinations and routine services, order and perform tests, and administer treatment deemed necessary by the examining physician. Should treatment be performed, the physician will fully inform me as to the nature of the procedure, the alternatives to treatment, and the risks involved. I will be given the opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand that the examining physician will discuss this with me and that additional consent(s) may be required.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for all charges resulting from treatment provided by Metropolitan Pediatrics, LLC, as well as any agency and/or legal fees incurred should my account be placed in a collection status. I agree to pay the balance due within 30 days of statement billing unless I have made other payment arrangements.

ASSIGNMENT OF BENEFITS: I authorize my insurance carrier(s) to remit payment of benefits for any claim to Metropolitan Pediatrics, LLC. I understand that any ineligible or non-covered expenses are my responsibility.

I assign Metropolitan Pediatrics, LLC, as an Authorized Representative to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits, and (4) release all medical information necessary to process my claims. I authorize any plan administrator or insurer to release any and all plan documents, insurance policy and/or settlement information upon written request from Metropolitan Pediatrics, LLC. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

 Signature of parent or guardian Print Name Relationship to patient Date