



# Patient Information Form

Gresham: 503-667-8878      Happy Valley: 503-261-1171  
Northwest: 503-295-2546      Westside: 503-531-3434

## Parent Information:

Name: \_\_\_\_\_  
Last First MI  
SSN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  M  F  
Marital Status:  Married  Single  Divorced  Widowed  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## Other Parent Information:

Name: \_\_\_\_\_  
Last First MI  
SSN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  M  F  
Marital Status:  Married  Single  Divorced  Widowed  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

## Billing Information:

Private Pay (no insurance)  
 Insurance (primary)      Eff. Date: \_\_\_/\_\_\_/\_\_\_  
Insurance Co: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Policyholder: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Policy#: \_\_\_\_\_  
Group#: \_\_\_\_\_ Copay: \$ \_\_\_\_\_

**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.

**X** \_\_\_\_\_  
Signature of Patient, Parent, or Legally Responsible Person  
Rev. 07/20/2016

\_\_\_\_\_   
Print Name

\_\_\_\_\_   
Relationship

**X** \_\_\_/\_\_\_/\_\_\_   
Date

## Patient Information:

New Patient?  Y  N

Name: \_\_\_\_\_  
Last First MI  
SSN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  M  F

## Other Children in Family:

Patient Here?  Y  N

Name: \_\_\_\_\_  
Last First MI  
SSN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  M  F

.....  
Patient Here?  Y  N

Name: \_\_\_\_\_  
Last First MI  
SSN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  M  F

.....  
Patient Here?  Y  N

Name: \_\_\_\_\_  
Last First MI  
SSN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  M  F

## Emergency Contact (other than spouse):

Name: \_\_\_\_\_  
Last First MI  
Relationship to Patient: \_\_\_\_\_  
Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_