Patient Information Form

Parent Information

Name: ______________________________
Last First MI

SSN: ____________ DOB: ___/___/___ ❑ M ❑ F

Relationship to Patient: ______________

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

Relationship to Patient: ______________

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Address: ______________________________

City/State/Zip: ______________________

Email: ______________________________

Home: (_____)__________ Cell: (_____)__________

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

Name: ______________________________
Last First MI

Relationship to Patient: ______________

Home: (_____)__________ Cell: (_____) __________

Billing Information

❑ **Private Pay (No Insurance)**

❑ **Insurance (Primary)** Eff. Date: ___/___/___

Insurance Co: ______________________

Employer: ______________________

Policyholder: ______________ DOB: ___/___/___

Policy#: ______________________

Group#: ____________ Copay: $__________

❑ **OHP:** ❑ CareOregon ❑ Providence Health Assurance ❑ Open Card

❑ **Insurance (Secondary)** 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

______________________ Print Name

__________ Relationship

X_____/_____/_____ Date

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