



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

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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: (____) _____