olson PEDIATRICS

Patient Registration Form

- **Primary Parent/Guardian:** *Please list parents/guardians separately regardless of marital or custodial status*

Name _____ SSN# _____ Date of Birth_____

Address _____ City _____ State _____ Zip_____

Please check box of preferred phone method for reaching you

☐Home Phone _____ ☐Cell Phone _____ Email _____

Marital Status: please choose all that apply

☐Married to _____ ☐Divorced/Sep. from _____ ☐I have full custody ☐Shared custody ☐N/A

Relationship to Patient(s) _____ ☐ I am the individual filling out this form

- **Secondary Parent/Guardian:**

Name _____ SSN# _____ Date of Birth_____

Address _____ City _____ State _____ Zip_____

Please check box of preferred phone method for reaching you

☐Home Phone _____ ☐Cell Phone _____ Email _____

Marital Status: please choose all that apply

☐Married to _____ ☐Divorced/Sep. from _____ ☐I have full custody ☐Shared custody ☐N/A

Relationship to Patient(s) _____ ☐ I am the individual filling out this form

- **Other Parent/Guardians/Emergency Contacts:**

Name _____ Cell Phone _____ ☐ I am the individual filling out this form

Relationship to patient(s) ☐ Step Parent, Married to _____ ☐ DHS Caseworker ☐ Other _____

Name _____ Cell Phone _____ ☐ I am the individual filling out this form

Relationship to patient(s) ☐ Step Parent, Married to _____ ☐ DHS Caseworker ☐ Other _____

- **Patient(s) Information:**

1.) Name _____ Date of Birth _____ M ☐ F ☐ Doctor_____

First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? _____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _____

2.) Name _____ Date of Birth _____ M ☐ F ☐ Doctor_____

First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? _____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _____

3.) Name _____ Date of Birth _____ M ☐ F ☐ Doctor_____
First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? _____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _____

4.) Name _____ Date of Birth _____ M ☐ F ☐ Doctor_____
First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? _____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _____

5.) Name _____ Date of Birth _____ M ☐ F ☐ Doctor_____
First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? _____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _____

- **Pharmacy Information:**

Name _____ Street Name _____ City _____

- **Insurance Information:**

Primary Insurance Company _____ Member ID# _____ Grp ID# _____

Subscriber Name _____ Subscriber DOB _____ Effective Date _____

Note: If secondary insurance applies, please provide that information below. Both insurance parties must be made aware that the other exists. If they do not, please contact necessary parties. Medicaid is always secondary to commercial insurance.

Secondary Insurance Company _____ Member ID# _____ Grp ID# _____

Subscriber Name _____ Subscriber DOB _____ Effective Date _____

Who referred you to our office? _____

Pharmacy Authorization:

I hereby authorize Olson Pediatric Clinic to electronically send prescriptions to a participating pharmacy of my choice. OPC may electronically receive information regarding my child's prescription history, drug interactions, prior authorization requirements, or requested substitutions.

Patient Centered Primary Care Home:

As a Patient Centered Care Home "Medical Home", OPC is committed to providing the highest quality patient centered care. OPC care will be delivered by a team of healthcare professionals including Physicians, Registered Nurses, and other Skilled Staff. I will be encouraged and supported as I become involved in my care. The goal is to ensure that my healthcare is coordinated so that I have the best possible health outcome.

Authorization and Consent for Treatment, Assigning of Benefits, Financial Responsibility, HIPAA Acknowledgment:

I hereby authorize Olson Pediatric Clinic to provide medical services to the above named patient(s) and to use and release medical information as required for treatment and health care operations. I hereby authorize Olson Pediatric Clinic to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Olson Pediatric Clinic all benefits for service rendered. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of service will result in additional charges. I have received or reviewed a copy of the current Notice of Privacy Practices.

Signature _____ **Printed Name** _____ **Date** _____