

PEDIATRIC HEART CENTER OF CENTRAL OREGON
Patient Registration Form

PATIENT INFORMATION

Patient Name (Last, First, Middle): _____

Address: _____

Home phone: _____

Patient date of birth: ____/____/____

Work phone: _____

Patient Social Security Number: ____ - ____ - ____

Cell phone: _____

Gender: Male Female

INSURANCE INFORMATION

Insurance Company	Subscriber Name	Subscriber Birthdate	Subscriber Address (if different from above)

RESPONSIBLE PARTY

Name (Last, First, Middle): _____

Address (if different from above): _____

Date of birth: ____/____/____

Social Security Number: ____ - ____ - ____

Gender: Male Female

Marital Status: Married Single Other

Employer: _____ **Phone Number:** _____

Is this your first visit to the Pediatric Heart Center of Central Oregon? Yes No

Other family members who are patients at the Pediatric Heart Center of Central Oregon (please list names):

I give permission for the following individuals to seek medical care for my child:

Name	Relationship To Child	Comments

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship:** _____

Address: _____

Phone: Home _____ Work _____ Cell _____

We appreciate your feedback. Comments?

FINANCIAL AGREEMENT

I, the undersigned,

do not have insurance coverage

have insurance coverage and authorize direct payment to the Pediatric Heart Center of Central Oregon (PHCCO).

I acknowledge that I will be financially responsible for all charges, whether or not paid by insurance. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. In addition, I authorize PHCCO to release information, as necessary, in order to facilitate treatment, payment, or other healthcare operations.

Signature: _____ Date: _____