

**PEDIATRIC HEART CENTER OF CENTRAL OREGON**  
**Patient Registration Form**

|   |  |                                 |   |
|---|--|---------------------------------|---|
| <b>PATIENT INFORMATION</b> (Please print Last, First, & Middle) |  | Home Phone: (    )              |   |
| Patient Name:   |  | Work Phone: (    )              |   |
|   |  | Cell Phone: (    )              |   |
| Address:  |  | City:                           | State and Zip Code:   |
| Patient Birth Date:<br>/ /                                      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Social Security Number:         | Referring Physician:  |
| Insurance Company   | Subscriber's name  | Subscriber's Address            | Subscriber's Birth Date<br>/ /                                    |
| 1.  |  |                                 | / /   |
| 2.  |  |                                 | / /   |
| <b>(PARENT OR GUARDIAN)</b>                                     |  |                                 |   |
| Name (Last, First, Initial):                                    |  |                                 |   |
| Mailing Address:  |  | City:                           | State and Zip:  |
| Birth Date:<br>/ /  | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Social Security Number:         | Marital Status (please circle one):<br>Married    Single    Other |
| Employer Name:  |  | Employer Address, City & State: |   |

**I GIVE PERMISSION FOR THE FOLLOWING INDIVIDUALS TO SEEK MEDICAL CARE FOR MY CHILD:**

| NAME | RELATIONSHIP TO CHILD | COMMENTS |
|------|-----------------------|----------|
|      |                       |          |
|      |                       |          |

**OTHER FAMILY MEMBERS WHO ARE PATIENTS AT PEDIATRIC HEART CENTER OF C. OREGON**

| NAME | NAME | NAME |
|------|------|------|
|      |      |      |

**OTHER INFORMATION**

Is This Your First Visit To Pediatric Heart Center of Central Oregon?    Yes    No

New Patients - How Did you Hear About Us?     Family/Friend     Physician Referral     Provider Directory     Advertisement (what source? \_\_\_\_\_)     Other \_\_\_\_\_

We appreciate your feedback. Comments? \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

|                        |               |             |
|------------------------|---------------|-------------|
| Name:                  | Relationship: | Home Phone: |
| Address, City & State: |               | Work Phone: |
|                        |               | Cell Phone: |

**FINANCIAL AGREEMENT**

I, the undersigned,  have insurance coverage,  do not have insurance coverage and authorize direct payment to Pediatric Heart Center of Central Oregon (PHCCO). I acknowledge that I will be financially responsible for all charges, whether or not paid by my 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.

**PHCCO may assess a service charge not to exceed \$25.00 for returned checks. Charges to PHCCO from their Bank for a returned check may also be assessed in addition to the service charge.**

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

Please print name: \_\_\_\_\_