Helena Pediatric Clinic Patient Registration

PATIENT INFORMATION
(Please use patient's Legal name)

First Name_____ **MI**_____ **Last Name**_____

DOB_____ **Birth Sex**: M or F **Patient Phone** _____

Goes by Name_____**Preferred Pronouns**_____

Mailing Address _____ City_____ State_____ Zip_____

Who does patient reside with?_____

List Other Children in Household: _____

Race (please check "x")

( ) American Indian **( )** White

( ) Multiracial **( )** Asian

( ) Black/African American

Ethnicity (please check "x")

( ) Hispanic/ Latino

( ) NOT Hispanic/Latino

Primary Language (please check "x")

( ) English

( ) Spanish

( ) Other _____

PARENT/GUARDIAN INFORMATION

First Name_____ **Last**_____

ADDRESS_____

DOB_____ SSN# _____-_____-_____

Cell#_____Home#_____

Work#_____

Email _____

Employer _____

Relationship to patient_____

PARENT/GUARDIAN INFORMATION

First Name_____ **Last**_____

ADDRESS_____

DOB_____ SSN# _____-_____-_____

Cell#_____ Home#_____

Work#_____

Email _____

Employer_____

Relationship to patient_____

BILLING ADDRESS *If different than Patients' address

Responsible Party _____ Relationship_____ PH#_____

Mailing Address _____City_____State_____Zip_____

I authorize my health care provider to collect and send information to the State of Montana imMTrax (IIS) Immunization information System. I understand that at any time I may revoke this authorization. This is a portal for immunizations.

( ) YES ( ) NO (please check "x")

Parent/Guardian Signature_____Date_____

Please Complete Reverse Side

INSURANCE INFORMATION

Primary Insurance

Company Name: _____Policy #_____Group #_____

Policy Holder_____DOB_____Relationship_____

Company Address_____Employer_____

Secondary Insurance

Company Name: _____Policy #_____Group #_____

Policy Holder_____DOB_____Relationship_____

Company Address_____Employer_____

*****We cannot withhold information from a biological parent without a legal document stating parent has no rights. If a stepparent or other person is allowed to bring the child in, please give us the name and phone number of that person below. This will remain in effect until parent states otherwise.*****

Name _____Relationship_____PH# _____

In case of Emergency who can we call locally (other than parent/guardian)_____PH#_____

It is the policy of Helena Pediatric Clinic to provide an effective means of communication for its patients. Helena Pediatric Clinic will make a sincere effort to accommodate all reasonable requests for accommodations to enhance communication with its patients. If accommodation is needed, please communicate your request to a Receptionist, during the intake process, who in turn will work with the Office Manager to make reasonable efforts to accommodate your request.

Parent/Guardian Signature_____Date_____