Helena Pediatric Clinic Patient Registration

PATIENT INFORMATION
(Please use patient's Legal name)

First Name______________________________ MI______ **Last Name**______________________________

DOB____________________ **Sex**: M or F (please circle) **Patient Phone (   )** ______________

Mailing Address ____ City___________ State_____ Zip________

With whom does patient reside? ______________________________________Relationship__________________

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 INFORMATION

Mother

First Name_______________ **Last**_________________

ADDRESS:____________________________________

DOB________________ SSN# ______-______-________

Cell# (____) ______-_______ Home# (____) ______-_______

Work # (_____) _______-________

Email: ____________________________________

Employer: __________________________________

PARENT INFORMATION

Father

First Name________________ **Last**____________________

ADDRESS:______________________________________

DOB_________________ SSN# ________-_______-_________

Cell# (_____) ______-_______ Home# (_____) ______-_________

Work # (____) _______-_________

Email: ______________________________________

Employer: ____________________________________

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

Name ____Relationship__________________PH# (____) ______-_______

Who locally to call in case of Emergency (other than parent) ______________________________PH# (____) ________-_________

BILLING ADDRESS *If different than Patients address

Responsible Party ____________________________________ Relationship______________ Contact # (____) ______-_______

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.

( ) 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__________________________________

IF YOU WANT US TO DISCUSS YOUR CHILD'S HEALTHCARE WITH SOMEONE OTHER THAN PARENTS/GUARDIAN PLEASE DOCUMENT HERE. IF SOMEONE CALLS AND THEY ARE NOT LISTED HERE WE CANNOT SPEAK TO THEM.____

RELATIONSHIP TO PATIENT____

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 an 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**_________________