OLYMPIA PEDIATRICS, PLLC.

Family Registration Form

Please print clearly. It is very important that we have your patient/family information correct

PRIMARY CONTACT PERSON FOR FAMILY (preferred contact person for reminder calls)

Circle One: Biological Mother/Father Step Mother/Father Adoptive Mother/Father Foster Mother/Father Legal Guardian Other_____

Name: _____ **Birth Date:** _____

SS# _____ **Do you live with patient?** ☐ Yes ☐ No

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Phone Numbers: Home _____ Cell _____ Work _____

Email Address: _____ **Name of Employer:** _____

Best Contact for Voice Messages: ☐ Home ☐ Cell ☐ Work

Best Contact for text Appointment Reminders: ☐ Home ☐ Cell ☐ Work

SECONDARY CONTACT PERSON FOR FAMILY

Circle One: Biological Mother/Father Step Mother/Father Adoptive Mother/Father Foster Mother/Father Legal Guardian Other_____

Name: _____ **Birth Date:** _____

SS# _____ **Do you live with patient?** ☐ Yes ☐ No

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Phone Numbers: Home _____ Cell _____ Work _____

Email Address: _____ **Name of Employer:** _____

Best Contact for Voice Messages: ☐ Home ☐ Cell ☐ Work

Best Contact for text Appointment Reminders: ☐ Home ☐ Cell ☐ Work

CUSTODY (if applicable)

Who has primary physical custody?

☐ Primary Contact (listed above) ☐ Secondary Contact (listed above) ☐ Other _____

BIOLOGICAL PARENTS

If contacts listed above are NOT the Biological Parents, We require BOTH Biological Parents (if known) to be listed below. This is required in order to obtain a more accurate family medical history.

Biological Mother: _____ **Birth Date:** _____

Biological Father: _____ **Birth Date:** _____

CHILDREN

Please **ONLY** list children in family that the **above parent information** applies to. If a child in the family has a different family Dynamic (such as a different parent), they must be on a different sheet.

Child 1: First Name _____ **MI** ____ **Last Name** _____ **DOB** _____
Gender Assigned at Birth ☐ Female ☐ Male **Primary Language Spoken** ☐ English ☐ Spanish ☐ Other _____
Ethnicity ☐ Not Hispanic ☐ Hispanic ☐ Unknown **Race** ☐ Native American ☐ Asian ☐ Black ☐ Pacific Islander ☐ White

Child 2: First Name _____ **MI** ____ **Last Name** _____ **DOB** _____
Gender Assigned at Birth ☐ Female ☐ Male **Primary Language Spoken** ☐ English ☐ Spanish ☐ Other _____
Ethnicity ☐ Not Hispanic ☐ Hispanic ☐ Unknown **Race** ☐ Native American ☐ Asian ☐ Black ☐ Pacific Islander ☐ White

Child 3: First Name _____ **MI** ____ **Last Name** _____ **DOB** _____
Gender Assigned at Birth ☐ Female ☐ Male **Primary Language Spoken** ☐ English ☐ Spanish ☐ Other _____
Ethnicity ☐ Not Hispanic ☐ Hispanic ☐ Unknown **Race** ☐ Native American ☐ Asian ☐ Black ☐ Pacific Islander ☐ White

Child 4: First Name _____ **MI** ____ **Last Name** _____ **DOB** _____
Gender Assigned at Birth ☐ Female ☐ Male **Primary Language Spoken** ☐ English ☐ Spanish ☐ Other _____
Ethnicity ☐ Not Hispanic ☐ Hispanic ☐ Unknown **Race** ☐ Native American ☐ Asian ☐ Black ☐ Pacific Islander ☐ White

(TURN OVER)

INSURANCE (if insurance cards are not presented at each visit, you may be considered self-pay)

Apple Health: Is this patient covered by Apple Health or ProviderOne? ☐ Yes ☐ No

Primary Insurance:

Name of Insurance Company: _____

Subscriber ID: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Does the Subscriber Live With Patient? ☐ Yes ☐ No Subscriber's Relationship to Patient: _____

Secondary Insurance:

Name of Insurance Company: _____

Subscriber ID: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Does the Subscriber Live With Patient? ☐ Yes ☐ No Subscriber's Relationship to Patient: _____

FINANCIAL GUARANTOR (this is the person that will receive billing statements in the mail)

Name: _____ Relationship to Patient: _____

Contact information for guarantor same as primary contact on first page ☐

Contact information for guarantor same as secondary contact on first page ☐

If contact information is different:

Address: _____ City: _____ State: _____ Zip _____

Phone Numbers: Home _____ Cell _____ Work _____

Name of Employer: _____

Please Read and Initial the Following:

_____ I understand that parents must agree on who the financial guarantor is. Parents must work out this arrangement amongst themselves for payment issues. Olympia Pediatrics cannot become involved with domestic arguments over who receives billing statements.

_____ I understand that if this becomes a recurring problem, we may be asked to find another practice that better suits my needs.

OFFICE POLICIES

Please Read and Initial the Following:

_____ I understand copies of the Co-Pay Policy, No Show Policy, Proof of Insurance Policy, and Notice of Privacy Practices are available in the office and on our website. I understand copies are available upon request. I understand that I am bound to the terms of the policies and failure to do so could result in dismissal.

_____ I understand that both biological parents, unless their parental rights have been terminated either through a court order or through the adoption process, have access to full disclosure of their child's medical information and can authorize someone to bring their child to their appointments in their absence. Access to medical information is not limited to the main custodial parent for access.

_____ I understand, in the interest of building a trusting relationship with our adolescents and teenagers, the providers may not be able to discuss all teenage issues discussed at appointments with the parents, unless the provider feels that the patient is a danger to themselves or has been abused.

_____ I authorize Olympia Pediatrics, upon my request, to fax any forms or immunization records to my child's school.

_____ I understand that Olympia Pediatrics provides immunization information the Washington State Immunization Information System.

_____ I understand that I am personally responsible for being aware of dates and times of my scheduled appointments.

_____ I understand that I am responsible for all charges, whether or not covered by insurance, and that all co-pays are due at the time of service.

_____ I understand the office requires 72 hours notice for prescription refills.

_____ I understand if there are Custody Orders in place, I must present current copies for my child's file. If custody issues interfere with our ability to provide proper medical care, you may be asked to find a facility that better suits your needs.

_____ I authorize the provider to release information, including records of the diagnosis, treatment, and examination rendered to my child during the period of care, to third party payers, my health insurance, my attorney, and/or other health practitioners.

_____ I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Olympia Pediatrics

_____	_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Relationship to Patient**	**Date**