BALLARD PEDIATRIC CLINIC

We need to update our records. Thank you for printing clearly.

PATIENT INFORMATION

NAME(First)____(M.I.)____(Last)____

Address____City / State / Zip____

Date of Birth____Age_____________ Gender ___ Male ___ Female

Preferred Language English ___ Other____________________________________

Ethnicity (circle) Unknown / Hispanic or Latino / Non-Hispanic or Latino / Decline to Answer

Race (circle) American Indian / Asian / Black or African American / Hawaiian or Pacific Islander / White / Decline

Who referred you to our office?____

Emergency Contact (Other than parent)____________________________________Phone___________________Relation_________

1. PARENT / GUARDIAN INFORMATION

___Mother ___Father Biological parent? Yes / No ___Guardian ___Foster Parent ___Step Parent

Name____Date of Birth_________________________________

Address (if different)____City/State/Zip________________________________

Social Security Number____Policy Holder on Insurance? ___ Yes ___ No

Primary Contact Phone____ Email____

Are we permitted to leave detailed messages on your contact phone numbers? ___ *Yes* ___ *No*

Parent Employer____ Occupation______________________________________

2. PARENT / GUARDIAN INFORMATION

___Mother ___Father Biological parent? Yes / No ___Guardian ___Foster Parent ___Step Parent

Name____Date of Birth_________________________________

Address (if different)____City/State/Zip________________________________

Social Security Number____Policy Holder on Insurance? ___ Yes ___ No

Secondary Contact Phone_______________________________________ Email____

Are we permitted to leave detailed messages on your contact phone numbers? ___ *Yes* ___ *No*

Parent Employer____ Occupation______________________________________

INSURANCE INFORMATION

Name of Insurance_______________________________________ Policy#____________________________Group#_______________

Subscriber Name____Date of Birth_____________________SSN___________________

Are you covered by Medicaid, DSHS, Molina, Apple or CHPW? ___Yes ___No (If yes, please give ProviderOne card to reception.)

Secondary Insurance______________________________________ Policy#____________________________Group#_______________

Subscriber Name____Date of Birth_____________________SSN___________________

ADDITIONAL INFORMATION

Who do your children live with?____

Please list the names of other children seen in our office:

Name____Date of Birth__________________________

Name____Date of Birth__________________________

Name____Date of Birth__________________________

ASSIGNMENT OF BENEFITS / CONSENT TO EXAM AND TREATMENT

I authorize payment of medical benefits to the physicians of Ballard Pediatric Clinic. I also authorize the release of any medical record information necessary to process the insurance claim. I understand that regardless of insurance coverage, I am responsible for my account and any balances due. I further give consent to have my child(ren) evaluated and treated by Ballard Pediatric Clinic and its associates. The above information is accurate and complete to the best of my knowledge.

Parent or Guardian Signature____Date_______________________________