It's very important we have your Patient/Family Information correct – PLEASE PRINT CLEARLY

PRIMARY CONTACT PERSON FOR FAMILY (This primary contact will be the **preferred contact person** for reminder calls)

Check one: ___ Biological-Mother ___ Step-Mother ___ Adoptive-Mother ___ Foster-Mother ___ Legal Guardian Other:____________________

___ Biological-Father ___ Step-Father ___ Adoptive-Father ___ Foster-Father ___ Legal Guardian Other:____________________

Name: ______________________________________ Home Phone: ____________________ Cell Phone: _____________________

Address: _____________________________________Work Phone: ____________________ SS#: ____________________________

City: _______________________________________ Email: ____

State: _____________ Zip: ______________ Birth Date: _______/______/________

Do you live with patient? ___Yes ___No Name of Employer : ____

Check preferred means of contact for messages: ___Home ___Cell ___Work ___Email

Check preferred means of contact for appointment reminders: ___Home ___Cell ___Work ___Email

SECONDARY CONTACT PERSON FOR FAMILY

Check one: ___ Biological-Mother ___ Step-Mother ___ Adoptive-Mother ___ Foster-Mother ___ Legal Guardian Other:____________________

___ Biological-Father ___ Step-Father ___ Adoptive-Father ___ Foster-Father ___ Legal Guardian Other:____________________

Name: ______________________________________ Home Phone: ____________________ Cell Phone: _____________________

Address: ___________________________________Work Phone: ____________________ SS#: ______________________________

City: _______________________________________ Email: ____

State: _____________ Zip: ______________ Birth Date: _______/______/________

Do you live with patient? ___Yes ___No Name of Employer : ____

WHO HAS PRIMARY PHYSICAL CUSTODY? (If applicable) ____

In order to obtain more accurate Family Medical History requirements, if contacts listed above are NOT the BIOLOGICAL PARENTS, we now necessitate BOTH BIOLOGICAL PARENTS (if known) to be listed (fill in any and all information if known):

Biological Mother: ____ Birth Date: ____/____/_____

Biological Father: ____ Birth Date: ____/____/_____

If either biological parent listed above has NO parental rights per a **SIGNED COURT ORDER,** a copy of that COURT ORDER is required to be on file.

EMERGENCY CONTACTS (Other than either the parent(s) or contact(s) listed above)

Name: ____ Relationship to Patient: _________________ Phone: ____________________

Name: ____ Relationship to Patient: _________________ Phone: ____________________

LIST ONLY CHILDREN IN FAMILY THAT THE ABOVE PARENTAL INFORMATION APPLIES TO

(If children have a different family dynamic then above - they must be on a different sheet)

	First Child ⇩	**Second Child** ⇩	**Third Child** ⇩	**Fourth Child** ⇩
First Name				
Mid. Initial				
Last Name				
Sex	___ Male ___ Female	___ Male ___ Female	___ Male ___ Female	___ Male ___ Female
Birth Date	_____/_____/__________	_____/_____/__________	_____/_____/__________	_____/_____/__________
Primary Language Spoken	___ English ___ Spanish List other:_______________	___ English ___ Spanish List other:_______________	___ English ___ Spanish List other:_______________	___ English ___ Spanish List other:_______________
Ethnicity	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown	___ Not Hispanic ___ Hispanic ___ Unknown
Race **(Check all that apply)**	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander

IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT YOU MAY BE CONSIDERED SELF-PAY

Is this patient cover by Apple Health or ProviderOne? ____Yes ____No

PRIMARY INSURANCE:

Subscribers Name: ____ Subscribers DOB: ___/___/____

Name of Ins. Company: __________________________________ Do you live with patient? ___Yes ___No Relationship to patient: ______________

Subscriber ID#: ____ Group #: _____________________________________

SECONDARY INSURANCE:

Subscribers Name: ____ Subscribers DOB: ___/___/____

Name of Ins. Company: __________________________________ Do you live with patient? ___Yes ___No Relationship to patient: ______________

Subscriber ID#: ____ Group #: _____________________________________

WHO IS THE FINANICAL GUARANTOR – If Financial Guarantor is a Contact on previous page only complete first line.

This is the person that will receive Billing Statements in the mail.
(Parents must agree on this and work arrangements out among themselves for payment issues.
Olympia Pediatrics cannot become involved with domestic arguments over who receives Billing Statements.
If this becomes a recurring problem you may be asked to find another practice that better suits your needs)

Printed Name: ____ Relationship to patient:___________________________

Address: ___________________________________ Home Phone _____________________Cell Phone ______________________

City: ____ State: ________ Zip: ______________ Birth Date: _______/______/________

Do you live with patient? ___Yes ___No Name of Employer **:** ____

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 by the terms of the policies and failure to do so could result in dismissal.

I understand 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 physician 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 immunizations records to my child's school.

I understand that Olympia Pediatrics provides immunization information to 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 24 hours notice for prescription refill requests.

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 physicians providing proper medical care you may be asked to find a facility that better suits your needs.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such 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.

SIGNATURE: ____ ______________________ ______/______/_________

Relationship to patient **Date**

PRINT NAME: ____