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 _____ Email: _____

City: _____ 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
Appt. Reminders: _____Home _____Cell _____Work _____Email
Medical Issues: _____Home _____Cell _____Work _____Email
Patient Recall Notices: _____Home _____Cell _____Work _____Email
Patient Portal: _____Text to Cell _____ Home Email _____ Work Email

I give my permission to allow detailed messages to be left on voice mail regarding any medical condition, treatment, and/or test results, for the above-named child. _____

Parent/Guardian Signature

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 _____ Email: _____

City: _____ 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 right per a SIGNED COURT ORDER a copy of that COURT ORDER is required to be on file.

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

WHO IS THE FINANICAL GUARANTOR – If Financial Guarantor is a Contact above, 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.
The staff of Drs. Nielsen, Resk, Stoeber and Uyesugi cannot become involved with domestic arguments over who receives Billing Statements.

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: _____

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
Who do you consider your Primary Care Physician?	__ Dr. Nielsen __ Dr. Resk __ Dr. Stoeber __ Dr. Uyesugi	__ Dr. Nielsen __ Dr. Resk __ Dr. Stoeber __ Dr. Uyesugi	__ Dr. Nielsen __ Dr. Resk __ Dr. Stoeber __ Dr. Uyesugi	__ Dr. Nielsen __ Dr. Resk __ Dr. Stoeber __ Dr. Uyesugi

I understand copies of the Financial Policy (which includes policies on No Show Appointments, Billing Fees, and Collections) and Notice of Privacy Practices are posted 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 the Patient Portal is in place for my benefit and if it is misused my access can be terminated by the practice.

I understand, in the interest of building a trusting relationship with our adolescents and teenagers, the providers may not be able to relay all teenage issues discussed at appointments with the parents, unless the physician feels the patient is a danger to themselves or has been abused. This confidential information will also not be accessible on the portal.

I authorize Drs. Clarke, Nielsen, Resk, and/or Stoeber, upon my request, to fax any forms or immunizations records to my child's school.

I understand that Drs. Clarke, Nielsen, Resk and Stoeber provide immunization information to the Oregon Immunization Information System, and I may opt out of having my child's information sent by notifying Drs. Clarke, Nielsen, Resk and/or Stoeber in writing.

I understand that reminder calls are for courtesy purposes only, and 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 agree to keep laboratory testing and referral appointments as ordered by the doctors.

I understand the office requires 2 business days 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 Drs. Clarke, Nielsen, Resk and/or Stoeber.

I Authorize Drs. Nielsen, Resk, Stoeber and/or Uyesugi to display pictures of my child(ren) within the office Yes__ No__

_____ _____

Print name Relationship to Child

_____ _____/_____/_____

Parent/Guardian Signature **Date**