Olson Pediatric Clinic, LLC.

Patient Registration Form

- **Primary Parent/Guardian:** *Please list parents/guardians separately regardless of marital or custodial status*

Name ____________________ SSN# ____________________ Date of Birth____________________

Address ____________________ City ____________________ State ________ Zip__________

Please check box of preferred phone method for reaching you

☐Home Phone ____________________ ☐Cell Phone ____________________ Email ____________________

Marital Status: please choose all that apply

☐Married to ____________________ ☐Divorced/Sep. from ____________________ ☐I have full custody ☐Shared custody ☐N/A

Relationship to Patient(s) ____________________ ☐ I am the individual filling out this form

- **Secondary Parent/Guardian:**

Name ____________________ SSN# ____________________ Date of Birth____________________

Address ____________________ City ____________________ State ________ Zip__________

Please check box of preferred phone method for reaching you

☐Home Phone ____________________ ☐Cell Phone ____________________ Email ____________________

Marital Status: please choose all that apply

☐Married to ____________________ ☐Divorced/Sep. from ____________________ ☐I have full custody ☐Shared custody ☐N/A

Relationship to Patient(s) ____________________ ☐ I am the individual filling out this form

- **Other Parent/Guardians/Emergency Contacts:**

Name ____________________ Cell Phone ____________________ ☐ I am the individual filling out this form

Relationship to patient(s) ☐ Step Parent, Married to ____________________ ☐ DHS Caseworker ☐ Other ____________________

Name ____________________ Cell Phone ____________________ ☐ I am the individual filling out this form

Relationship to patient(s) ☐ Step Parent, Married to ____________________ ☐ DHS Caseworker ☐ Other ____________________

- **Patient(s) Information:**

1.) Name ____ Date of Birth ____________ M ☐ F ☐ Doctor__________

First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? ____________________

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: ____________________

2.) Name ____ Date of Birth ____________ M ☐ F ☐ Doctor__________

First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? ____________________

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: ____________________

3.) Name ____ Date of Birth ____________ M ☐ F ☐ Doctor___________
First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? ____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _______________________________

4.) Name ____ Date of Birth ____________ M ☐ F ☐ Doctor___________
First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? ____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _______________________________

5.) Name ____ Date of Birth ____________ M ☐ F ☐ Doctor___________
First Full Middle Last

Address: Same as primary guardian? Y ☐ N ☐ If No, who does this child live with? ____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _______________________________

- **Pharmacy Information:**

Name ____ Street Name ______________________ City _______________

- **Insurance Information:**

Primary Insurance Company ________________________________ Member ID# _________________________ Grp ID# ________________

Subscriber Name ____ Subscriber DOB _____________ Effective Date ________________

Note: If secondary insurance applies, please provide that information below. Both insurance parties must be made aware that the other exists. If they do not, please contact necessary parties. Medicaid is always secondary to commercial insurance.

Secondary Insurance Company ________________________________ Member ID# _________________________ Grp ID# _______________

Subscriber Name ____ Subscriber DOB _____________ Effective Date ________________

Who referred you to our office? ____

Pharmacy Authorization:
I hereby authorize Olson Pediatric Clinic to electronically send prescriptions to a participating pharmacy of my choice. OPC may electronically receive information regarding my child's prescription history, drug interactions, prior authorization requirements, or requested substitutions.

Patient Centered Primary Care Home:
As a Patient Centered Care Home "Medical Home", OPC is committed to providing the highest quality patient centered care. OPC care will be delivered by a team of healthcare professionals including Physicians, Registered Nurses, and other Skilled Staff. I will be encouraged and supported as I become involved in my care. The goal is to ensure that my healthcare is coordinated so that I have the best possible health outcome.

Authorization and Consent for Treatment, Assigning of Benefits, Financial Responsibility, HIPAA Acknowledgment:
I hereby authorize Olson Pediatric Clinic to provide medical services to the above named patient(s) and to use and release medical information as required for treatment and health care operations. I hereby authorize Olson Pediatric Clinic to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Olson Pediatric Clinic all benefits for service rendered. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of service will result in additional charges. I have received or reviewed a copy of the current Notice of Privacy Practices.

Signature ____________________________________ **Printed Name** ____________________________________ **Date** _______________