VALLEY CHILDREN'S CLINIC

4011 Talbot Road South, Suite 220, Renton, Washington 98055. 425-656-5300

PATIENT REGISTRATION

PATIENT NAME _____ TODAY'S DATE_____
FIRST MIDDLE LAST

STREET ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

DATE OF BIRTH (DOB)_____ AGE_____ ☐ MALE or ☐ FEMALE

PATIENT'S BROTHERS/SISTERS

_____ DOB_____ _____ DOB_____

_____ DOB_____ _____ DOB_____

_____ DOB_____ _____ DOB_____

PARENTS OR GUARDIANS RESPONSIBLE FOR BILL

PRIMARY CONTACT

NAME_____ DOB_____ RELATIONSHIP TO PATIENT _____

STREET ADDRESS_____ SS#_____

CITY_____STATE_____ZIP_____ EMPLOYER _____

BEST NUMBER TO BE REACHED _____ (CELL/HOME) WORK NUMBER _____ EXT_____

ALTERNATE NUMBER_____ (CELL/HOME) ☐ MESSAGES MAY BE LEFT AT THIS NUMBER

☐ OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

SECONDARY CONTACT

NAME_____ DOB_____ RELATIONSHIP TO PATIENT _____

STREET ADDRESS_____ SS#_____

CITY_____STATE_____ZIP_____ EMPLOYER _____

BEST NUMBER TO BE REACHED _____ (CELL/HOME) WORK NUMBER _____ EXT_____

ALTERNATE NUMBER_____ (CELL/HOME) ☐ MESSAGES MAY BE LEFT AT THIS NUMBER

☐ OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

INSURANCE INFORMATION

PRIMARY INSURANCE_____ SECONDARY INSURANCE _____

INSURANCE ADDRESS_____ INSURANCE ADDRESS _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

POLICY HOLDER _____DOB_____ POLICY HOLDER _____DOB_____

GROUP # _____ EFFECTIVE DATE _____ GROUP # _____ EFFECTIVE DATE _____

SS# or ID#_____ SS# or ID#_____

WHO WILL BE PATIENT'S PRIMARY CARE PHYSICIAN (PCP) IN THIS OFFICE _____

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, NEARBY RELATIVE OR FRIEND TO BE NOTIFIED (NOT AT SAME ADDRESS)

NAME_____ RELATIONSHIP TO PATIENT _____

BEST NUMBER TO CALL _____ ALTERNATE NUMBER _____

ASSIGNMENT AND RELEASE

I authorize Valley Children's Clinic to treat the minor patient named above. I understand that it is Valley Children's Clinic policy that the parent or guardian who requests treatment is financially responsible for services rendered. I hereby authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim. I understand that I will be charged a service charge of 1% per month for any amount outstanding more than 60 days past due and a $10.00 service charge each time I neglect to pay my copayment at the time of service.

SIGNED_____ RELATIONSHIP TO PATIENT _____