

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 _____