pediatric associates
OF THE NORTHWEST

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2701 NW Vaughn Street
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7150 SW Dartmouth Street
Tigard, OR 97223
(503) 968-3480

Beaverton Office
14795 SW Murray Scholls
Drive, Suite 121
Beaverton, OR 97007
(503) 673-10771

PATIENT

Name (Last, First, Middle): _____ Preferred Name: _____

Date of Birth: _____ Gender: □ M □ F Primary Physician: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Patient Declined

Race: ☐ Asian ☐ Chinese ☐ Filipino ☐ Japanese ☐ White ☐ American Indian or Alaska Native ☐ Hispanic ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ European ☐Middle Eastern or North African ☐Other Race ☐Patient Declined

Interpreter Needed: □ No □ Yes Language Preference: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ □ OK to text If the patient is a teen, is this the patient's phone? □ No □Yes

Email: _____ □ OK to email If the patient is a teen, is this the patient's email? □ No □Yes

Emergency Contact (other than parent or guardian):

Name Relationship to Patient Phone Number

Referral Source: □ Family Member □ Friend □ Coworker □ Hospital/ER □ Website □ Internet Search □ Physician Referral

□ Insurance Company □ Medicaid □ Other: _____

Preferred Pharmacy: Name: _____ Phone: _____

Address: _____

PARENT/GUARDIAN

Parent 1 Name: _____ Date of Birth: _____

Address: □ Same as Patient

Address City, State, Zip

Primary Phone: _____ □ OK to text Type: □ Home □ Cell □ Work

Email: _____ □ OK to email Occupation: _____

Parent 2 Name: _____ Date of Birth: _____

Address: □ Same as Patient

Address City, State, Zip

Primary Phone: _____ □ OK to text Type: □ Home □ Cell □ Work

Email: _____ □ OK to email Occupation: _____

INSURANCE

Primary Insurance Company: _____

Claims Address: _____ Phone Number: _____

Policy #: _____ Group #: _____ Copay: _____ Effective Date: _____

Subscriber: _____ Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance Company: _____

Claims Address: _____ Phone Number: _____

Policy #: _____ Group #: _____ Copay: _____ Effective Date: _____

Subscriber: _____ Date of Birth: _____

Relationship to Patient: _____

I hereby authorize Pediatric Associates of the Northwest to provide medical services to the above-named patient and to use and release medical information as required for treatment, payment and healthcare operations. I authorize Pediatric Associates of the Northwest to recognize me as a participant of the Patient-Centered Primary Care Home Program. I have received a copy of the current Notice of Privacy Practices and the Financial Policy of Pediatric Associates of the Northwest.

Signature: _____ Date: _____.

PANW offers helpful administrative information by unencrypted text messaging and email, such as appointment reminders. There is some level of risk with such information in a regular text or email, which could be read by someone other than you. Please let us know if you would like us to communicate with you by text message or email, by clicking the OK to text or email next to the phone or email where you'd prefer to receive such messaging. You may select one, both or none of the methods. We do not use unencrypted methods of communication to discuss diagnoses, medications, or treatment specific to your health. Such discussions will be done in person, over the phone, or through our patient portal. Please initial that you have read this statement and agree to the indications you have made above:

Initial here

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