CHILDREN'S HEART CENTER OF CENTRAL OREGON
Patient Registration Form

PATIENT INFORMATION

Patient Name (Last, First, Middle)**:**_____

Address: _____

_____

Home phone: _____ **Patient date of birth:** _____/_____/_____

Work phone: _____ **Patient Social Security Number:** _____-_____-_____

Cell phone: _____ **Gender:** ☐ Male ☐ Female

INSURANCE INFORMATION

Insurance Company Primary Insurance Carrier	**Subscriber Name**	**Subscriber Birthdate**	**Subscriber Address** (if different from above)
Secondary Insurance			

RESPONSIBLE PARTY

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

Address (if different from above)**:** _____

_____

Date of birth: _____/_____/_____ **Social Security Number:** _____-_____-_____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Other

Is this your first visit to the Children's Heart Center of Central Oregon? ☐ Yes ☐ No

How did you hear about our office? _____

Other family members who are patients at the Children's Heart Center of Central Oregon (please list names):

_____

_____

I give permission for the following individuals to seek medical care for my child:

Name	Relationship To Child	Comments

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship:**_____

Address: _____

Phone: Home_____ Work_____ Cell_____

We appreciate your feedback. Comments?

_____

_____

FINANCIAL AGREEMENT

I, the undersigned,

☐ do not have insurance coverage

☐ have insurance coverage and authorize direct payment to the Children's Heart Center of Central Oregon (CHCCO).

I acknowledge that I will be financially responsible for all charges, whether or not paid by insurance. A 10% annual charge will be assessed for invoices not paid within 30 days. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. In addition, I authorize CHCCO to release information, as necessary, in order to facilitate treatment, payment, or other healthcare operations.

When a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, I understand that a fee of $100-$150 will be charged for missed appointments ("no shows") and appointments that are not cancelled within a 24-hour advance notice.

Signature:_____ Date:_____