CLINIC NETWORK
PULLMAN REGIONAL HOSPITAL

Palouse Heart Center
Palouse Pediatrics
Palouse Psychiatry & Behavioral Health
Palouse Pulmonology & Sleep Medicine
Pullman Family Medicine
Palouse Health Center

CHILD - PATIENT REGISTRATION

Patient's Legal Name: _____ Last 4 Digits S.S. #:_____
(First) (Middle Initial) (Last)

Preferred Name: _____ Marital Status: _____

Gender Identity: _____ Preferred Pronouns: _____

Due to updated Federal guidelines, we are required to obtain specific patient information. Please make sure you answer questions 1-6. Thank you.

(1) Patient's Birthdate: _____ **(2) Patient's Age:** _____ **(3) Sex at Birth:** _____

(4) Race (Check One)
□ American Indian/Alaska Native
□ Native Hawaiian/Other Pacific Island
□ African American
□ Asian
□ White
□ Other Race
□ Declined

(5) Ethnicity (Check One)
□ Not Hispanic or Latino
□ Hispanic or Latino
□ Declined

(6) Primary Language (Please List)
□ English
□ _____
□ Declined

Home Address: _____ City: _____ State:_____ Zip Code: _____

Mailing Address: _____ City: _____ State:_____ Zip Code: _____

Home #: _____ Work #: _____ Cell#: _____

Email: _____

Parent/Guardian 1 Name: _____ DOB:_____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Address: _____ City:_____ State:____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

Parent/Guardian 2 Name: _____ DOB:_____ Last 4 Digits S.S. #:_____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: ____ Zip Code:_____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

Name of Other: □ **Stepmother** □ **Stepfather** □ **Grandparent** □ **Foster Parent** □ **Legal Guardian** □ **Power of Attorney**

Name: _____ Gender:_____ DOB:_____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: ____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address:_____ Occupation: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone #: _____

Primary Care Physician (If Different): _____ Phone #: _____

Other Provider: _____ Phone #: _____

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EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell #: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone #: _____

Preferred Mail Order Pharmacy: _____ Phone #: _____

INSURANCE INFORMATION

Name of Primary Insurance: _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ___

Address: _____ City: _____ State: _____ Zip Code: _____

Customer Service Phone #: _____ Relationship to Patient: _____

Name of Secondary Insurance *(If Applicable):* _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ___

Address: _____ City: _____ State: _____ Zip Code:_____

Customer Service Phone #: _____ Relationship to Patient: _____

Tertiary Insurance *(If Applicable) :* _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ___

Address: _____ City: _____ State: ____ Zip Code: _____

Customer Service Phone #: _____ Relationship to Patient: _____

I acknowledge the above Insurance/Demographic information is correct and that regardless of my insurance status, I am solely responsible for payment of any professional services rendered to me, or on my, behalf, whether or not paid by my insurance company.

_____
Parent or legally authorized individual signature Date

_____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian)