

KITSAP CHILDREN'S CLINIC,LLP

9951 Mickelberry Rd., Suite 101
Silverdale, WA 98383
360-692-9362 Fax 360-692-6214

450 S. Kitsap Blvd., Suite 2300
Port Orchard, WA 98366
360-895-0216 Fax 360-895-7919

ACCOUNT # _____

UPDATED

PATIENT REGISTRATION

DATE _____

PLEASE PRINT

PATIENT NAME _____ BIRTHDATE _____ M F

BILLING ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

STREET ADDRESS _____

GUARDIAN INFORMATION

IF ADDRESS AND PHONE ARE THE SAME AS PATIENT PLEASE WRITE "SAME."

IF LEGAL GUARDIAN IS OTHER THAN FATHER / MOTHER PLEASE PUT THE APPROPRIATE INFORMATION IN THIS SECTION.

FATHER'S NAME _____ DOB: _____ PHONE# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SSN# _____ EMPLOYER _____

ADDRESS _____ PHONE# _____

MOTHER'S NAME _____ DOB: _____ PHONE# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SSN# _____ EMPLOYER _____

ADDRESS _____ PHONE# _____

BILLING INFORMATION

PRIMARY PHYSICIAN _____

INSURANCE: YES NO IF YES: COMPLETE THE FOLLOWING INFORMATION.

INSURANCE #1 TYPE _____ ID# _____ GROUP _____

SUBSCRIBER NAME _____ BIRTHDATE _____

INSURANCE #2 TYPE _____ ID# _____ GROUP _____

SUBSCRIBER NAME _____ BIRTHDATE _____

EMERGENCY INFORMATION

Someone not living in the same household as the child. ie. grandparents, close friend(s), aunt/uncle.

NAME _____ PHONE# _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

RELEASE OF BENEFITS AND INFORMATION: I authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required to process any claim(s) resulting from medical or surgical services rendered.

Signature of parent / guardian or patient if 18 or older

Date