Westside Pediatric Clinic, P.C.

9555 SW Barnes Rd, Suite 270 Portland, OR 97225

Please choose your **PRIMARY** physician:

___ Deborah Purcell M.D. ___ Lori Hankenson M.D. ___ Eman Lutfi M.D.
___ Geraldine Kempler M.D. ___ Nitza Quiles M.D. ___ Faye Johnson M.D.

Patient Information:

_____ _____ _____
DOB Patients Full Name Race/Ethnicity Sex

_____
Home Address City/State/Zip

Sibling(s):_____
Name Race/Ethnicity Sex DOB

_____
Name Race/Ethnicity Sex DOB

Preferred language:_____

Primary Guardian: (who the patient resides with)

_____
DOB Sex Full Name SSN#

_____
Phone #1 Phone #2 Occupation Email

_____
Insurance Company **Subscriber's Name**/ID #/Policy # Copay Amount $

Secondary Guardian:

_____
DOB Sex Full Name SSN#

_____
Phone #1 Phone #2 Occupation Email

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

_____
Insurance Company **Subscriber's Name**/ID #/Policy # Copay Amount $

Third Contact: (if unable to reach you directly)

_____
Relation to Patient Full Name Phone Number(s)

How did you hear about us:_____

I realize I am responsible to pay all non-covered services. I acknowledge this information is true and accurate and to the best of my ability.

_____
Name **Relation to patient** **Date**