Westside Pediatrics Clinic, P.C.

2022

9555 SW Barnes Rd, Suite# 270 Portland, OR 97225

Please choose your PRIMARY physician: ____ Geraldine Kempler, MD

_____ Faye Johnson, MD _____ Nitza Quiles, MD _____ Melissa Giustini, MD

Patient Information:

_____ _____ _____

DOB Patient 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 to the best of my ability.

_____

Name Relation to patient Date