WESTSIDE PEDIATRIC CLINIC

9155 SW Barnes Rd
Suite 270
Portland, OR 97225

Please select your **PRIMARY** physician:

___ Geraldine Kempler, MD ___ Faye Johnson, MD ___ Melissa Giustini, MD

___ Saera Watanabe, MD ___ Amanda Bailey, MD

How did you hear about us? _____

PATIENT INFORMATION:

_____ _____ _____ _____
DOB PATIENT FULL NAME RACE/ETHNICITY SEX

_____ _____ _____
HOME ADDRESS CITY/STATE ZIP

SIBLINGS: _____
NAME DOB SEX

_____
NAME DOB SEX

PREFERRED LANGUAGE:_____

PRIMARY GUARDIAN: (WHO PATIENT RESIDES WITH) _____

SSN#_____ FULL NAME: _____ DOB/SEX: _____

PHONE#1: _____ PHONE#2: _____ EMAIL: _____

INSURANCE COMPANY: _____ SUBSCRIBER NAME/ID AND GROUP#: _____

SECONDARY GUARDIAN:_____

SSN# _____ FULL NAME:_____ DOB/SEX:_____

PHONE#1: _____ PHONE#2: _____ EMAIL: _____

ADDRESS: (IF DIFFERENT FROM ABOVE) _____

INSURANCE COMPANY: _____ SUBSCRIBER NAME/ID AND GROUP#: _____

THIRD CONTACT: (IF UNABLE TO REACH YOU): _____

RELATION TO PATIENT: _____ NAME: _____ PHONE NUMBER(S):_____

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

Name: _____ Relation to patient: _____ Date: _____