Patient Registration Form

sound pediatrics
22180 Olympic College Way NW
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Phone (360) 626-4031

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: _____ Male _____ Female

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

Home Phone: _____Other Day Phone:_____

- As part of the federal healthcare reform, the federal government requires us to obtain primary race and language to measure delivery of healthcare services and distribution of vaccines. Collecting accurate data is the basic foundation to identify differences and improve the quality of care. Please answer the following questions for the **patient only.**

Is your child Hispanic, Spanish or Latino?_____

What race do you consider your child to be? _____

What is your child's primary language?_____

PARENT/GUARDIAN INFORMATION

Relationship of Guardian to Patient: Self _____ Parent _____ Other _____

Last Name: _____ First Name: _____ DOB:_____

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

Home Phone : _____Work/Day Phone:_____

Cell Phone : _____ E-mail Address: _____

Send bills to this address: _____ yes _____ no

Additional Parent/Guardian Information:

Relationship of Guardian to Patient: Self _____ Parent _____ Other _____

Last Name: _____ First Name: _____ DOB:_____

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

Home Phone : _____ Work/Day Phone:_____

Send Bills to this address: _____ yes _____ no

Emergency Contact Name: _____ Relationship to patient:_____

Emergency Phone: _____

CONSENT

By signing below I certify the information provided is accurate to the best of my knowledge. I authorize my insurance benefits to be paid directly to Sound Pediatrics and consent to the release of any information required to process my claim. I also understand I am financially responsible for any balance that is not covered by my insurance.

Parent/Guardian Signature: _____ Date:_____