North Olympic Healthcare NETWORK

North Olympic Healthcare Network
240 West Front Street | Suite A
Port Angeles, WA 98362-2609
(360) 452-7891 P | (360) 452-8087 F

NEW PATIENT REGISTRATION – CHILD (0-18YRS)

CHILD INFORMATION

First Name _____

Last Name _____

Gender Male ☐ Female ☐ Date of Birth _____

Child Social Security Number _____

PRIMARY INFORMATION (where and whom the child lives with)

Parent/Guardian Name _____

Child lives with: *Both Parents ☐ Mother ☐ Father ☐ Foster Parents ☐ Grandparents ☐ Legal Guardian ☐ Emancipated Minor ☐ Other* _____

Child's Home Address _____

_____

Mailing Address (if different than above) _____

_____

Contact Phone # _____Email Address _____

EMERGENCY CONTACT INFORMATION

Contact Name _____

Contact Phone # _____ Relationship _____

PATIENT NAME _____DATE OF BIRTH _____

FEES AND BILLING
No patient will be denied service due to inability to pay. We offer a Sliding Fee Discount program which can provide discount fees for certain services. To see if you qualify please complete the information below.

Gross Monthly Household Income $ _____
Number of Family Members in Your Household _____
I decline to see if I qualify for Sliding Fee Discount ☐

ASSISTANCE
Does the patient need a language interpreter for appointments**?** ☐ Yes ☐ No
Does the patient need a sign language interpreter for appointments? ☐ Yes ☐ No
Does the patient need transportation assistance for appointments? ☐ Yes ☐ No

INSURANCE INFORMATION

Does the child have health insurance? Yes ☐ No ☐
If no, would you like information on signing up for health insurance? Yes ☐ No☐

Insurance Name _____

Policy Number _____ ___Group # _____

Subscriber Name _____Subscriber Date of Birth _____

Subscriber relationship to child _____

Is there a secondary insurance? Yes ☐ No ☐

Insurance Name _____

Policy Number _____Group Number _____

Subscriber Name _____Subscriber Date of Birth _____

Subscriber relationship to child _____