KARTINI CLINIC
for Children & Families

3530 N. Vancouver Ave. Suite 400
Portland, Oregon 97227
P: 503.249.8851 F: 503.282.3409
www.kartiniclinic.com

PATIENT INFORMATION SHEET

PATIENT'S LEGAL NAME: _____
First *Middle* *Last*

Date of birth *(MM/DD/YYYY)*: _____ Gender: _____ SSN: _____

Street Address (including apartment #): _____

City: _____ State: _____ Zip: _____

PRIMARY CARE DOCTOR: _____
Name *Phone Number*

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN LEGAL NAME: _____
First *Middle* *Last*

DOB *(MM/DD/YYYY)*: _____ SSN: _____ Email: _____

Primary Phone#: _____ Secondary Phone#: _____
❑*Home* ❑*Cell* ❑*Work* ❑*Home* ❑*Cell* ❑*Work*

Address: ❑Same as patient/or: _____

Employer: _____ Occupation: _____ Phone#: _____

PARENT/GUARDIAN LEGAL NAME: _____
First *Middle* *Last*

DOB *(MM/DD/YYYY)*: _____ SSN: _____ Email: _____

Primary Phone#: _____ Secondary Phone#: _____
❑*Home* ❑*Cell* ❑*Work* ❑*Home* ❑*Cell* ❑*Work*

Address: ❑Same as patient/or: _____

Employer: _____ Occupation: _____ Phone#: _____

PERSON NOT LIVING AT YOUR ADDRESS TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Phone #: _____ Relation to Patient: _____

Name: _____ Phone #: _____ Relation to Patient: _____

I understand that I am financially responsible for all charges whether covered by insurance or not. I hereby authorize the doctors of Kartini Clinic to provide such medical, psychological, and psychiatric services, either regular or emergency, as may be determined to be in the best interest of those members of my immediate family, as listed above, who are minors. This authorization shall continue and be in full force and effect until revoked in writing by me.

I understand, and agree that regardless of my insurance status, I am fully responsible for the balance of account for all services rendered. I also understand that my insurance is a contract between me and my insurance company, and that verification of benefits does not guarantee payment. I understand I am financially responsible for all charges that are not paid by my insurance company.

If debt collection becomes necessary, I understand I am responsible for paying all costs of collection, including a reasonable attorney's fee and court costs.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY CHILD'S ACCOUNT, REGARDLESS OF THEIR AGE.

_____
*Signature of Guarantor **TO BE SIGNED IN PERSON AT FIRST APPOINTMENT*** *Date*

_____
Printed Name