The solo pediatric practices of
Magdalenne Corso MD, PC; James Resk, MD, PC; Troy Stoeber, MD, LLC; Kristine Bugakov MD, LLC
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Patient Registration

PLEASE PRINT CLEARLY *– It's very important we have your Patient/Family Information correct*

PATIENT INFORMATION

Legal Name: ____ **DOB**: ______/______/______ ❑ **Male** ❑ **Female**

Address: ____
Street City State Zip

Primary Care Provider: ❑ Dr. Corso ❑ Dr. Resk ❑ Dr. Stoeber ❑ Dr. Bugakov **Language**: ❑ English ❑ Spanish ❑: Other ________________________

Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Unknown **Race**: ❑ White ❑ Black ❑ Native American ❑ Asian ❑ Pacific Islander ❑ Other: ________________

*****If children have a different family dynamic then the above child – they must be on a different form*****

Sibling Name: ____ **Sibling Name**: ____
DOB: _____/_____/_____ ❑ Male ❑ Female DOB: _____/_____/_____ ❑ Male ❑ Female

Sibling Name: ____ **Sibling Name**: ____
DOB: _____/_____/_____ ❑ Male ❑ Female DOB: _____/_____/_____ ❑ Male ❑ Female

PRIMARY CONTACT PERSON FOR FAMILY (this primary contact will be the **preferred contact person** for Reminder calls)

Check one: ❑ Biological-Parent ❑ Step-Parent ❑ Adoptive-Parent ❑ Foster-Parent ❑ Legal Guardian Other: ____________________________

Preferred way to receive health information and resources: ❑ Written ❑ Verbal ❑ Other: ________________

Name: ____ ❑ **Male** ❑ **Female** **DOB**: _______/_______/_______

Address: ❑ same as patient ____
Street City State Zip

Primary Phone: (______)____________________ ❑ Home ❑ Cell **Secondary Phone**: (______)____________________ ❑ Home ❑ Cell

I give my permission to leave detailed and confidential voice mail at: ❑ Primary Phone ❑ Secondary Phone ___________ **PLEASE INITIAL**

Preferred means of contact for Appt. Reminders and Recall Notices: ❑ Phone ❑ Text ❑ Email

Email Address: ____

Does this person have Legal custody/authority of patient? ❑ Yes ❑ No **Does this person live with patient**? ❑ Yes ❑ No

SECONDARY CONTACT PERSON FOR FAMILY

Check one: ❑ Biological-Parent ❑ Step-Parent ❑ Adoptive-Parent ❑ Foster-Parent ❑ Legal Guardian Other: ____________________________

Name: ____ ❑ **Male** ❑ **Female** **DOB**: _______/_______/_______

Address: ❑ same as patient ____
Street City State Zip

Primary Phone: (______)____________________ ❑ Home ❑ Cell **Secondary Phone**: (______)____________________ ❑ Home ❑ Cell

I give my permission to leave detailed and confidential voice mail at: ❑Primary Phone ❑Secondary Phone ___________ **PLEASE INITIAL**

Does this person have Legal custody/authority of patient? ❑ Yes ❑ No **Does this person live with patient**? ❑ Yes ❑ No

EMERGENCY CONTACT (PROXY) INFORMATION (*Other than Guardian*) – Consent for treatment in absence of parent or legal guardian. **Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.**

I hereby appoint,

Name: ____ **Phone**: _________________________ **Relationship**: _________________________

Name: ____ **Phone**: _________________________ **Relationship**: _________________________

___________ (**PLEASE INITIAL**) I give my permission for the above-named person(s) to schedule, confirm, and cancel appointments and accompany my child(ren) to visits and, in general, act on my behalf during the visit to authorize treatment, including but not limited to vaccinations and/or procedures for my child.

****Please continue on other side****

BILLING AND INSURANCE ❑ **No Insurance (Self Pay)**

Primary Insurance

Company Name: ________________________________ **ID#**: ________________________ **Group #**: ______________________

Policy Holder Name: ______________________________ **DOB**: _____/_____/_____ **Relation to patient**: ___________________

Secondary Insurance

Company Name: ________________________________ **ID#**: ________________________ **Group #**: ______________________

Policy Holder Name: ______________________________ **DOB**: _____/_____/_____ **Relation to patient**: ___________________

IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT YOU MAY BE CONSIDERED SELF-PAY

WHO HAS PRIMARY PHYSICAL CUSTODY? (IF APPLICABLE) ____

In order to obtain more accurate Family Medical History requirements, if contacts listed above are NOT the BIOLOGICAL PARENTS< we now require BOTH BIOLOGICAL PARENTS (if known) to be listed (fill in all known information):

Biological Mother: ____ Birth Date: ______________________

Biological Father: ____ Birth Date: _______________________

PLEASE REVIEW & SIGN

I understand copies of the Financial Policy (which includes policies on No Show Appointments, Billing Fees, and Collections) and Notice of Privacy Practices are posted in the office and on our website. I understand copies are available upon request. I understand that I am bound by the terms of the policies and failure to do so could result in dismissal.

I understand both biological parents, unless their parental rights have been terminated either through a court order or through the adoption process, have access to full disclosure of their child's medical information and can authorize someone to bring their child to their appointments in their absence. Access to medical information is not limited to the main custodial parent for access.

I understand the Patient Portal is in place for my benefit and if it is misused my access can be terminated by the practice.

I understand, in the interest of building a trusting relationship with our adolescents and teenagers, the providers may not be able to relay all teenage issues discussed at appointments with the parents, unless the physician feels the patient is a danger to themselves or has been abused. This confidential information will also not be accessible on the portal.

I authorize Drs. Corso, Resk, Stoeber and/or Bugakov, upon my request, to fax any forms or immunizations records to my child's school.

I understand that Drs. Corso, Resk, Stoeber and/or Bugakov provide immunization information to the Oregon Immunization Information System, and I may opt out of having my child's information sent by notifying Drs. Corso, Resk, Stoeber and/or Bugakov in writing.

I understand that reminder calls are for courtesy purposes only, and I am personally responsible for being aware of dates and times of my scheduled appointments.

I agree to keep laboratory testing and referral appointments as ordered by the doctors.

I understand the office requires 2 business days' notice for prescription refill requests.

I understand if there are Custody Orders in place I must present **current copies** for my child's file. If custody issues interfere with our physicians providing proper medical care you may be asked to find a facility that better suits your needs. **I authorize** the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners.

I understand that I am responsible for all charges whether or not covered by insurance and that all co-pays are due at the time of service.

I understand that Drs. Corso, Resk, Stoeber and/or Bugakov do not bill workers Compensation. Information on workers compensation can be obtained through the patients' employer.

In the event of a motor vehicle accident, **I understand** Drs. Corso, Resk, Stoeber, and/or Bugakov will need the accident claim and policy information at the time of the initial visit.

I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Drs. Corso, Resk, Stoeber and/or Bugakov.

I authorize Drs. Corso, Resk, Stoeber and/or Bugakov to display pictures of my child(ren) within the office **Yes**____ **No**____

Printed name of Parent/Guardian: ____ Date: ________________________

Signature of parent/Guardian: ____ Relationship to patient: ___________________________