NUNM Health Centers
3025 SW Corbett Ave
Portland, OR 97201

Pediatric Patient Intake

Patient's Legal Name:

_____
Last Name *First Name* *Middle Name*

Patient's Date of Birth_____Age: _____ Gender:(circle one) F M

Homeless Y N At Risk for Homelessness Y N

Ethnic Group (select one): Hispanic_____ Non-Hispanic_____

Race (you may select more than one): Asian_____ Black_____ White_____

Native Alaskan_____ Pacific Islander_____ American Indian_____

Contact Information for Parent or Guardian (*Please circle preferred number for contacting you*)

Name:

_____Phone:_____
Parent or Guardian

_____Phone:_____
Parent or Guardian

Address:_____

City: _____ State: _____ Zip code: _____

Home telephone: _____ Work phone: _____

Cell phone: _____ Email address: _____

Primary Language:_____ Interpreter needed? Yes No

Guarantor: The person who is financially responsible

Name:_____Relationship to the patient:_____

Social Security Number: _____ Gender: M F Birth Date:_____

Address: (if different from patient) _____

City:_____State:_____Zip:_____

Occupation _____ Hrs per week_____

Employer _____ Address: _____

City _____ State _____ Zip _____ Phone _____

Name and phone number of child's Primary Care Physician (PCP):

_____

Physician Name *Phone*

The NUNM Health Centers Billing Dept requires that *all* insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit today.

Insured's Name_____

Insurance Company_____

Claims Address_____

City_____ State_____ Zip_____

Phone#:_____ Group/Policy#:_____

Subscriber ID#:_____ Patient ID#:_____

Please be prepared to present your insurance card at each visit.

I certify that the above information is true and correct to the best of my knowledge:

Signature:_____ Date:_____