



Siskiyou Pediatric  
Clinic LLP

700 SW Ramsey Ave. Suite 204  
Grants Pass, OR 97527  
Phone (541) 955-5683  
Fax (541) 955-0983

We want to provide you with the best care possible; to do so we need all pertinent medical records. Please answer the following questions to help us obtain the necessary patient history.

In the last **5 years** has your child:

- Received medical care or vaccinations outside of Oregon?
- Had more than one Pediatrician?
- Been hospitalized outside of the area?
- Been seen by a Counselor (Options)?
- Seen by a specialist?

**Do you consider your child to be medically complex?** Yes  No

*Revised 04/30/2025*



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**New Patient information**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Mailing Address if different: \_\_\_\_\_

**Parent/Guardian** (Leave address blank if it's the same as information above)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relation to Child: \_\_\_\_\_ SSN: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Email: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relation to Child: \_\_\_\_\_ SSN: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Email: \_\_\_\_\_

**Primary Insurance Information**

Name of Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Secondary Insurance Information**

Name of Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Sibling Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

**Alternate Contact Information (Step-Parents, Grand parents, etc.)**

*Parental consent required for anyone other than biological parents or legal guardians*

Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION
(Release of Information)

PATIENT NAME:

DATE OF BIRTH:

I hereby authorize: SISKIYOU PEDIATRIC CLINIC, LLP
700 SW RAMSEY AVE., STE. 204
GRANTS PASS, OR 97527

To release records to:

To request records from: (check one)

Name:

Address:

Phone #:

Fax #:

For the purpose(s) of: Transferring Care Continuity of Care Other:

By initialing the spaces below, I specifically authorize the release of the following medical records, of such records exist. Please initial for release of records (do not check spaces).

- Entire Medical Records
All Pertinent Medical Records (for last 2 years)
Immunization Records
Laboratory Reports/Pathology Reports
Physical Therapy records
Diagnostic Imaging Reports
Other (specify):
This authorization is limited to the following treatment:
This Authorization is limited to the following time-period:
This Authorization is limited to Worker's Comp claims for injuries of:

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

- HIV/AIDS information
Mental health information
Genetic testing information
Drug/Alcohol diagnosis, treatment, or referral information

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. This Authorization shall remain in effect for one (1) year from the date signed, unless terminated sooner in writing.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to our Medical Records Department at: Siskiyou Pediatric Clinic, 700 SW Ramsey Ave., Ste 204, Grants Pass, OR 97527 and state that you are revoking this authorization.

Signature of patient or legally responsible person

Relationship to patient

Date

Printed Name of responsible person\*

Phone # of responsible person

\*In the event a legal representative other than parents of a minor child signs this Authorization, documentation of legal authority must be attached (e.g., Healthcare Power of Attorney or Court appointed Health Care Representative.) Resource (foster) parents are not permitted to sign this Authorization. It must be signed by a DHS Representative.



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## Parental Consent

Child's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, (Parent/Legal Guardian) give permission for the people listed below to bring my son/daughter in for their medical appointment at Siskiyou Pediatric Clinic, LLP. It is recommended by Siskiyou Pediatric Clinic, LLP that the parent/legal guardian is present at all medical appointments; however, we understand this is not possible at all times. By signing below, you understand and agree that the person(s) listed below will be able to make medical decisions including immunizations, medical procedures, etc. on your behalf. This document will remain on file and will not change unless another consent form is filled out.

\_\_\_\_\_  
Parent/Legal Guardian Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Name of Authorized Person to Bring in Patient and Relationship

\_\_\_\_\_  
Name of Authorized Person to Bring in Patient and Relationship

\_\_\_\_\_  
Name of Authorized Person to Bring in Patient and Relationship