DATE_____

SPOKANE pediatrics
A CHAS Health Clinic

Kimberly Grandinetti, MD, FAAP
Timothy Crum, MD, FAAP
Kristin Edgehouse, MD, FAAP
Veronica Jessick, MD

PATIENT INFORMATION

PATIENT NAME:_____
FIRST MI LAST NICKNAME

BIRTH DATE:_____**SEX**_____

Patient 13 & over Contact Information: Cell Phone: _____**E-MAIL:** _____

RACE:
☐ AMERICAN INDIAN/ALASKA NATIVE
☐ ASIAN
☐ BLACK/AFRICAN AMERICAN
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
☐ WHITE
☐ PREFER NOT TO ANSWER

ETHNICTY:
☐ HISPANIC/LATINO
☐ NOT HISPANIC/LATINO
☐ PREFER NOT TO ANSWER

PREFERRED LANGUAGE:
☐ ENGLISH
☐ OTHER: _____
☐ PREFER NOT TO ANSWER

LIST ANY ADDITIONAL FAMILY MEMBERS ON NEXT PAGE.

PARENT/GUARDIAN INFORMATION:

PARENT 1:_____ PARENT 2:_____

RELATION TO CHILD:_____ RELATION TO CHILD:_____

LAST 4 DIGITS OF S.S. #:_____ LAST 4 DIGITS OF S.S. #:_____

BIRTH DATE:_____ BIRTH DATE:_____

ADDRESS:_____ ADDRESS:_____

CITY:_____ST:_____ZIP CODE:_____ CITY:_____ST:_____ZIP CODE:_____

PRIMARY PHONE:_____ PRIMARY PHONE:_____

EMPLOYER:_____ EMPLOYER:_____

WORK PHONE: _____ WORK PHONE: _____

PRIMARY INSURANCE:_____ SECONDARY INSURANCE: _____

Please have insurance card ready at check in so that we can scan it. Thank you.

In case of emergency:_____ Relationship:_____

Phone Number: _____

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Name:_____DOB_____SEX:_____

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If you are registering more than 4 children, please ask the front desk for an additional form.

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APPOINTMENT REMINDER/PATIENT COMMUNICATION

By providing your contact information below, you are granting permission to be contacted via those communication channels for appointment reminders, reminders to schedule your next appointment and important announcements about our practice.

Parent 1 Cell Phone _____

Parent 2 Cell Phone _____

Home Phone _____

Email_____

YES, I WOULD LIKE ACCESS TO PATIENT PORTAL FOR MY CHILDREN UNDER 13 YEARS OF AGE USING THE EMAIL I HAVE PROVIDED ABOVE OR: _____

Preferred method of contact for appointment confirmation/important announcements (**Only mark one**):
☐ TEXT ☐ CALL ☐ EMAIL PRIMARY CONTACT NAME:_____

Please list all patients for which this information is applicable:

1) _____DOB_____

2) _____DOB_____

3) _____DOB_____

4) _____DOB_____

5) _____DOB_____

6) _____DOB_____

I hereby grant Spokane Pediatrics permission to contact me via an automated phone/text/email system. I authorize Spokane Pediatrics to leave a message on this device.

Signature _____Date_____