



Pediatric Patient Registration Form

Kaniksu Health Services does not discriminate in its services, treatments, programs, activities, or employment regardless of race, color, religion, national origin, age, physical or mental disability, veteran status, or sex, including gender identity and sexual orientation.

...providing its communities with affordable and accessible healthcare.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Birth Date:	Social Security #		Sex at Birth: M / F
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
PRIMARY PARENT/GUARDIAN CONTACT INFORMATION			
Contact Full Name:			Birth Date:
Phone #:	Relationship to Patient:		
Email:			
SECONDARY PARENT/GUARDIAN CONTACT INFORMATION			
Contact Full Name:			Birth Date:
Phone #:	Relationship to Patient:		
COMMUNICATION			
<p>Your health care is important to us. In order to provide you with the best possible care, we would like to occasionally send convenient text messages to you about your health care and services we offer. To authorize KHS to send you texts about your health, such as preventive care or health screenings you are due for, please sign below. By signing, I am agreeing to receive promotional texts from KHS, and I understand I am not required to receive such automated texts, and my agreement is not a condition of receiving care, services, or promoted items from KHS.</p>			<p>For Office Use Only: If signed, select "Expanded Texts" in NextGen.</p>
<p>Patient Signature: _____</p>			<p>Employee Initials: _____</p>
PRIMARY INSURANCE INFORMATION			
Medical Insurance:	Policy Holder Name:	Birth Date:	
<input type="checkbox"/> No Health Insurance			
<p>As a Federally Qualified Health Center, we are required to collect the following information for statistical purposes only. No individual information is submitted. Your cooperation helps us improve healthcare for all. Thank you.</p>			
Ethnicity	Are you Hispanic/Latino?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race	<input type="checkbox"/> White	<input type="checkbox"/> Black/ African American	<input type="checkbox"/> Native Hawaiian / Other Pacific Islander
	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Other
Language	What is your preferred language, including sign language? _____		
Farmworkers	In the past 2 years, have you or a member of your family worked in agriculture (fields, orchards, etc.) seasonally as the primary source of income?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, does this person change residence as a part of their work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you or a member of your family stopped migrating to work in agriculture due to disability or old age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Living Situation	<input type="checkbox"/> Rent/Own a Home <input type="checkbox"/> Homeless <input type="checkbox"/> Other (please describe) _____		
Reduced Fees	Are you interested in participating in our sliding fee scale program? <input type="checkbox"/> Yes <input type="checkbox"/> No		<p>(Could result in reduced fees, even for insured)</p> <p>Please Initial _____</p>
<p>*The sliding fee scale program is in place to meet the needs of the uninsured or underinsured, providing reduced costs on most services for those who qualify. No one will be denied access to services at KHS, as services are offered regardless of insurance status or ability to pay.</p>			
Family Income	Our annual household income before taxes is: \$ _____		<input type="checkbox"/> No annual income
	There are _____ people in my household.		

I hereby agree that the above information is true and correct to the best of my knowledge. I hereby authorize Kaniksu Health Services to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied. In the event that insurance benefits are paid directly to me, I will endorse KHS all checks for such payments. I also authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby agree that I am financially responsible for all charges incurred for the services provided.

Parent/Guardian signature

Parent/Guardian name (print)

Date



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CONSENT FOR TREATMENT OF A MINOR CHILD

Child's Name

Date of Birth

Parent/Legal Guardian

Phone Number

Relationship to the Minor Child

Parent/Legal Guardian

Phone Number

Relationship to the Minor Child

Authorized Caregiver's Information:

Caregiver's Name

Relationship to Minor Child

Phone number

Caregiver's Name

Relationship to Minor Child

Phone Number

The above named caregiver shall be authorized to consent for all medical and/or dental treatment, for the above named child, which may be required during my absence. I agree to pay for all services provided to my child that the caregiver authorized. If circumstances permit and/or if Kaniksu Health Services needs to contact me please contact me at the following phone number: _____.

This consent serves as permission for treatment by Kaniksu Health Services, for the above named child. This authorization shall remain **in effect for one year from the signing date** unless otherwise revoked in writing and submitted to Kaniksu Health Services prior to expiration date.

Signature of Parent/Legal Guardian

Date

*****Note: Consents are NOT required in emergency situations.**

Medical, Dental, Behavioral Health, Pediatrics: 6615 Comanche Street, Bonners Ferry, ID 80805, (208) 267-1718

Medical, Dental, Behavioral Health, Pediatrics: 30410 Hwy 200, Ponderay, ID 83852, (208) 265-6252

Medical, Behavioral Health, Pediatrics: 6509 Hwy 2, Priest River, ID 83865, (208) 448-2321

Pediatrics, Behavioral Health: 420 N. 2nd Ave, Sandpoint, ID 83864, (208) 265-2242

VA Clinic: 420 N. 2nd Ave, Sandpoint, ID 83864, (208) 263-0450

Administrative Offices: 301 Cedar St #206, P.O. Box 2160, Sandpoint, ID 83864, (208) 263-7101

www.kaniksuhealthservices.org