PATIENT REGISTRATION FORM

Patient Information:

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Male or Female Primary Language: _____

Ethnicity: Hispanic/ Non-Hispanic/ Unknown/ Decline to answer
Race: Asian/ Black/ American Indian or Alaska Native/ Caucasian/ Other: _____/Decline to answer

Patient Address:

Street: _____ Town/City _____ ZIP _____

Preferred Phone : _____Alternative Phone : _____

Who is here with patient today? _____ Relationship _____

Siblings: Name & DOB _____ _____

_____ _____

Consent to Treat:
Are there any other adults (other than parent/guardian) who are permitted to bring the patient in for exam/treatment: Yes or No Please Identify:
1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Parent/ Guardian: #1

Name: _____ Relationship: _____ DOB: _____

Lives with patient: Yes or No Preferred Phone# _____

Email: _____

Employer: _____ Occupation: _____

Parent/ Guardian: #2

Name: _____ Relationship: _____ DOB: _____

Lives with patient: Yes or No Preferred Phone# _____

Email: _____

Employer: _____ Occupation: _____

If parents are divorced or separated, please fill out this section:
Who has custody of the patient: _____
Is there any legal documentation that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child medical treatment?
Yes or No If so, please explain: _____
*** If yes, a copy of documentation is required.

Please see other side

PATIENT REGISTRATION FORM

Insurance:

Primary Insurance Policy Holder's Name: _____ DOB _____

SSN: _____ Insurance Carrier: _____
Group # _____ Policy # _____

Secondary Insurance Policy Holder's Name: _____ DOB _____

SSN: _____ Insurance Carrier: _____
Group # _____ Policy # _____

Who should receive billing statements: _____

Emergency Contacts: (other than parents or legal guardians)

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Acknowledgements:

I consent to the medical treatment and immunization schedule as recommended by the AAP, and as deemed advisable in the judgment of my physician/providers at Pediatric Associates, LLC. _____(initial)

Assignment of Insurance Benefits and authorization to release information: I hereby transfer and assign Pediatric Associates, LLC all rights title and interest in any payment due for services rendered. Pediatric Associates, LLC may disclose all or any part of the patient's record as needed to obtain compensation for services. _____ (initial)

Financial Agreement. The undersigned agrees, whether he/she signs as agent or patient, that they agree to pay any patient balance as per their insurance policy. I understand that it is my responsibility to pay any co-pay, deductible, co-insurance or any other balance not paid by my insurance. Self-pay arrangements can be made in the absence of insurance, and I am responsible for paying the rates as present for services rendered by Pediatric Associates, LLC. Payment is to be made to Pediatric Associates, LLC, I understand that unpaid balances may be subject to collections. _____ (initial)

Notice of Privacy Practice Acknowledgement

I have received Pediatric Associates, LLC Notice of Privacy Practice

Sign _____ Date _____

If patient declines to sign: Staff Signature _____ Date_____

Today's Date _____ Form completed by: _____