Patient Registration *(Pediatric)*

Chart #

Patient Information

Date ______________

Patient________________________________ Sex: ☐M ☐F DoB__/__/__ SS# ______________

Mother/Guardian________________________________ DoB__/__/__ SS# ______________

Address________________________________ Home Phone ______________

City/State/Zip________________________________ Occupation______________

Employer________________________________ Work Phone ______________

Father/Guardian________________________________ DoB__/__/__ SS# ______________

Address________________________________ Home Phone ______________

City/State/Zip________________________________ Occupation______________

Employer________________________________ Work Phone ______________

Sibling________________________________ Sex: ☐M ☐F DoB__/__/__ SS# ______________

Sibling________________________________ Sex: ☐M ☐F DoB__/__/__ SS# ______________

Sibling________________________________ Sex: ☐M ☐F DoB__/__/__ SS# ______________

Children live with: ☐ Mother ☐ Father ☐ Guardian ______________

Emergency Contact Person________________ Relation________________ Phone ______________

Party Responsible for Payment of Medical Services: ☐ Father ☐ Mother ☐ Guardian ☐ Both ______________

Who referred you to our office?________________________________

How did you hear about our practice? ☐ Referral ______________ ☐ Friend/Family ☐ Phone Directory ☐ Internet ☐ Newspaper ☐ Magazine ☐ Other ______________

Insurance Information

Primary________________________________ Claims Address______________

Policy #________________________________ Group #______________ Co-payment $______________

Secondary________________________________ Claims Address______________

Policy #________________________________ Group #______________ Co-payment $______________

Name of Insured________________________________ DoB__/__/__ Relation______________

Medicaid/Champus/Other________________________________ Current Card #______________

Physician Listed on Card________________________________ Phone ______________

Authorization of Treatment and Assignment of Benefit

I authorize ______________________to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to ______________________for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following:______________________

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature________________________ Relationship________________ Date______________

Witness' signature________________________________ Date______________

☐ I prefer to do my own insurance filing. Signed ________________________ Date______________

HIPAA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.

500-41
Rev. 7/08

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Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

Name_______________________________
Phone_______________________________
Name_______________________________
Phone_______________________________

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

Name_______________________________
Phone_______________________________
Name_______________________________
Phone_______________________________

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

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- Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number.

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Please be aware that a cell phone is not a secure and private line.

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL". ☐ Yes ☐ No

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No

____
PATIENT NAME *print* (Parent / Guardian, if under 18 years)

_______________________________ Date ______________
PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Notes

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Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

  Name____________________
  Phone____________________
  Name____________________
  Phone____________________

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

  Name____________________
  Phone____________________
  Name____________________
  Phone____________________

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

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____
PATIENT NAME *print* (Parent / Guardian, if under 18 years)

____________________ Date ____________
PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Notes

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Patient Registration *(Pediatric)*

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Patient____________________ Sex: ☐M ☐F DoB___/___/___ SS# ____________

Mother/Guardian____________________ DoB___/___/___ SS# ____________

Address____________________ Home Phone ____________

City/State/Zip____________________ Occupation____________

Employer____________________ Work Phone ____________

Father/Guardian____________________ DoB___/___/___ SS# ____________

Address____________________ Home Phone ____________

City/State/Zip____________________ Occupation____________

Employer____________________ Work Phone ____________

Sibling____________________ Sex: ☐M ☐F DoB___/___/___ SS# ____________

Sibling____________________ Sex: ☐M ☐F DoB___/___/___ SS# ____________

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How did you hear about our practice? ☐ Referral ____________ ☐ Friend/Family ☐ Phone Directory ☐ Internet ☐ Newspaper ☐ Magazine ☐ Other ____________

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Primary____________________ Claims Address____________

Policy #____________________ Group #____________ Co-payment $____________

Secondary____________________ Claims Address____________

Policy #____________________ Group #____________ Co-payment $____________

Name of Insured____________________ DoB___/___/___ Relation____________

Medicaid/Champus/Other____________________ Current Card #____________

Physician Listed on Card____________________ Phone ____________

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Witness' signature____________________ Date____________

☐ I prefer to do my own insurance filing. Signed ____________________ Date____________

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