Pediatric Care Center

Patient Registration Form

Date:________________________________

Patient Information

Last Name: ____________________ First Name: ____________________ Middle Name: ____________________

Date of Birth:____/____/________ Age:______ Sex:______ SSN#:________-________-________

Race: ☐ African-American ☐Caucasian ☐Other ☐Decline to Respond

Ethnicity: ☐African-American ☐Caucasian ☐Hispanic ☐Other ☐Decline to Respond

Insurance Information

Primary Insurance Company Name:____

Policy Number:____ Group Number:____________________

Policy Holder Name:____ DOB:____/____/________

Relationship to Patient:____

Secondary Insurance Company Name:____

Policy Number:____ Group Number:____________________

Policy Holder Name:____ DOB:____/____/________

Relationship to Patient:____

Mother/Legal Guardian

Name:____

Address:____

____

Home Phone:____

Cell Phone:____

Email:____

DOB:____/____/________

SS#:____

Marital Status:

☐Single ☐Married ☐Divorced ☐Widowed

Father/Legal Guardian

Name:____

Address:____

____

Home Phone:____

Cell Phone:____

Email:____

DOB:____/____/________

SS#:____

Marital Status:

☐Single ☐Married ☐Divorced ☐Widowed

Who is the primary caregiver? ☐Both ☐Mother ☐Father ☐Other

If applicable, who has primary custody? ☐Both ☐Mother ☐Father

Other______________________________ (Please provide legal documents for any alternative custody arrangements.)

Emergency Contact (Other than Parent)

Name:______________________ Relationship:______________________

Home Phone:______________________ Cell Phone:______________________

PLEASE LIST ALL PERSONS WHO MAY SCHEDULE APPOINTMENTS, CALLS FOR MEDICAL ADVICE OR BRING YOUR CHILD TO THE OFFICE FOR TREATMENT (I.E GRANDPARENTS, BABYSITTER, AUNT). THESE INDIVIDUALS WILL BE ASKED TO PRESENT IDENTIFICATION AT THE TIME OF VISIT. IF SOMEONE OTHER THAN THESE PERSONS CONTACTS US RELATIVE TO YOUR CHILD, WE WILL CONTACT THE PARENTS OR GUARDIAN FOR PERMISSION TO TREAT OR ADVISE. IN THE EVENT OF AN EMERGENCY, WE WILL TREAT AND MAKE EVERY ATTEMPT TO CONTACT THE PARENT OR GUARDIAN.

NAME	RELATIONSHIP	PHONE NUMBER

Additional Information

Preferred Language: ______________________

Preferred Provider: ______________________

Pharmacy Name: ______________________

Pharmacy Address: ______________________

Pharmacy Phone Number:______________________

Authorization

As a courtesy, Pediatric Care Center will verify and file insurance, but the practice cannot guarantee payment, I understand that I am financially responsible for service rendered as and when charges are incurred. I hereby authorize Pediatric Care Center and/or the rendering physician(s) to release all medical information required by insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to Pediatrics Care Center.

Uses of Protected Health Information to Contact You

We may use your protected health information to contact you by phone or via e-mail at any other location that you may specify and leave a message regarding appointment reminders, insurance items and any calls pertaining to your child's clinical care, including lab and x-ray results with information about treatment alternatives or other health related benefits and services that in our opinion may be of interest to you.

This authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original.

Consent to release information acquired in the course of examination and/or treatment in regards to treatments, payments or services and operations is understood and explained to you in the Notice of Privacy Practices.

______________________ ______________________

Parent/Guardian Signature Date