Patient Registration *(Pediatric)*

Patient Information Date ___/___/___ Chart No. ☐

Patient _____ Sex: ☐ M ☐ F DoB___/___/___ SS#_____

Race/Ethnicity ☐ Hispanic/Latino ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Other

Mother/Guardian _____ DoB___/___/___ SS#_____

Address _____ Home Phone _____

City/State/Zip _____ Work Phone _____

Employer _____ Email _____

Father/Guardian _____ DoB ___/___/___ SS#_____

Address _____ Home Phone _____

City/State/Zip _____ Work Phone _____

Employer _____ Email _____

Children live with: ☐ Mother ☐ Father ☐ Guardian _____

Emergency Contact Person _____ Relationship _____ Phone _____

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

Primary Pharmacy Location _____ Phone _____ Fax _____

Insurance Information

Primary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Name of Insured _____ Relationship _____ DoB ___/___/____

Secondary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Name of Insured _____ Relationship _____ DoB ___/___/___

Medicaid/Champus/Other _____ Current Card # _____

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 the 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 current guidelines for the 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 _____