# Pediatric Associates, LLP

## Patient Registration

*Date:*_____/_____/_____ *Acct #:* _______________

*Last Name:* ________________________ *First Name:* ________________________ *MI:* _____
*Nickname*: ___________________________ *D.O.B.:* _____/_____/_____ *Sex*: Male / Female
*Primary Language:* __________________
*Ethnicity:* Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

**Additional Siblings:**

*Last Name:* ________________________ *First Name:* ________________________ *MI:* _____
*Nickname*: ___________________________ *D.O.B.:* _____/_____/_____ *Sex*: Male / Female
*Primary Language:* __________________
*Ethnicity:* Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

*Last Name:* ________________________ *First Name:* ________________________ *MI:* _____
*Nickname*: ___________________________ *D.O.B.:* _____/_____/_____ *Sex*: Male / Female
*Primary Language:* __________________
*Ethnicity:* Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

**Mailing Address:**

*Address*: ____________________________________________________________________
*City:* ______________________________________ *State:* __________ *Zip Code:* __________
*Home Phone*: (______) ________ - ___________

**Father:**

*First Name*: ______________________________ *Last Name:* ___________________________
*Date of Birth:* ____ / ____ / ____ *Lives with patient?* Yes / No
*Cell Phone*: (____) ______ - ___________ *Home Email:*_______________________________
*Work Phone*: (____) ______ - ___________ *Work Email*: ______________________________
*Employer:* ______________________________ *Occupation:* ____________________________

**Mother:**

*First Name*: ______________________________ *Last Name:* ___________________________
*Date of Birth:* ____ / ____ / ____ *Lives with patient?* Yes / No
*Cell Phone*: (____) ______ - ___________ *Home Email:*_______________________________
*Work Phone*: (____) ______ - ___________ *Work Email*: ______________________________
*Employer:* ______________________________ *Occupation:* ____________________________

**Emergency Contact:** *(other than parents)*
*Name*: _______________________________________ *Phone:* (______) ________ - _________

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**Insurance**:

***Primary Policy***: *Policy Holder's Name*: ________________________________________

*Policy Holder's Birth Date*: ____ / ____ / ____ *Policy Holder's SSN*_______-_______-_______

*Policy Holder's Sex:* Male / Female

*Insurance Carrier:* ________________________________________________

*ID#* ____________________________________ *Group #* __________________________

***Secondary Policy***: *Policy Holder's Name*: ________________________________________

*Policy Holder's Birth Date*: ____ / ____ / ____ *Policy Holder's SSN*_______-_______-_______

*Policy Holder's Sex:* Male / Female

*Insurance Carrier:* ________________________________________________

*ID#* ____________________________________ *Group #* __________________________

***If parents are divorced or separated please fill out this section:***

*Who has custody?* ____________________________________________________________

*Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?* **Yes** / **No**

***If yes, please explain and provide a copy of any legal paperwork that supports this restriction.***

__________________________________________________________________________

**How would you ideally prefer to be contacted regarding? (circle one):**

***Medical Issues:*** Home Phone / Work Phone / Cell Phone / Home E-mail

***Appointment Reminders***: Home Phone / Cell Phone / Home E-mail / Work E-mail

***Recall Notices***: Home Address / Home Phone / Work Phone / Cell Phone / Home E-mail

***Billing Statements***: Home Address / Home E-mail / Work E-mail

***General Practice Notices:*** Home Address / Home Phone / Cell Phone / Home E-mail

***Patient Portal Notifications***: Cell Phone / Home E-mail / Work E-mail

**Additional Questions:**

*Who should receive billing statements?* ________________________________________

***List address to send billing statements. (If different from residential address)***

*Name*: ______________________________________________________________________

*Address*: ____________________________________________________________________

*City:* ____________________________________ *State:* __________ *Zip Code:* __________

*Home Phone*: (______) ________ - ___________

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*Due to patient confidentiality, please list below if you wish to allow any family member or any close friends to bring your child(ren) into the office for medical care. Also, we may communicate with the following individuals regarding appointments and medical information or course of treatment. I understand that this will remain in effect until I give written notice to Pediatric Associates to remove any of the persons listed below. (If left blank, parents will be the only ones authorized.)*

__________________________ ____________________________ (______) _________ - __________
(*Name*) (*Relationship*) (*Telephone*)

__________________________ ____________________________ (______) _________ - __________
(*Name*) (*Relationship*) (*Telephone*)

______ *(initial) Effective April 21, 2014, Pediatric Associates will begin utilizing the DrFirst National prescribing system. We are required to obtain your authorization, which will allow us to obtain prescription benefits as well as formulary guidelines from your insurance carrier. This consent will also allow us to obtain any prescription activity from the national database to assist us in obtaining very important information, which includes drug interactions, etc…*

______*(initial) You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.*

______*(initial) Some insurance companies have determined that annual physical exams must be billed separately from the treatment of any active problems encountered at the same time. We are required by this rule to bill your annual exam as a physical and not by any active diagnosis you may have. For example, if there is an active problem that requires treatment/ medication and/or a new test to be performed (i.e. ADHD or strep throat), you may be charged in addition to your annual exam an appropriate level of service charge. Therefore, it is possible you will receive two office visit charges for services rendered at the time of your appointment.*

I ACKNOWLEDGE BY SIGNING BELOW THAT I HAVE RECEIVED THE ***NOTICE OF PRIVACY PRACTICES AND NOTICES OF INDIVIDUAL RIGHTS***. I AUTHORIZE PEDIATRIC ASSOCIATES TO PROVIDE MEDICAL CARE TO MY CHILD(REN). I ALSO AUTHORIZE PEDIATIC ASSOCIATES TO FURNISH MY CHILD'S IMMUNIZATION INFORMATION TO MEDICAL FACILITIES, SCHOOLS, AND DAYCARES. BY SIGNING BELOW, I HEREBY CONSENT FOR PEDIATRIC ASSOICATES TO USE OR DISCLOSURE INFORMATION ABOUT MY CHILD(REN) (OR ANOTHER PERSON FOR WHO I HAVE AUTHORITY TO SIGN) THAT IS PROTECTED UNDER FEDERAL LAW, FOR TH SOLE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. YOU MAY REFUSE TO SIGN THIS CONSENT FORM. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

FATHER/GUARDIAN
SIGNATURE:__________________________________________ DATE: _____/_____/_____

MOTHER/GUARDIAN
SIGNATURE:__________________________________________ DATE: _____/_____/_____