PATIENT REGISTRATION FORM (PEDIATRICS)

Patient's first name: **Middle name:** **Last name:** **Suffix:** **Nickname:**

_____ _____ _____ _____ _____

Date of birth:_____ **Sex at birth(circle):** Male/Female **Preferred pronoun:** He/Him-She/Her-They/Them

Race (Circle all that apply, optional but helpful) **Ethnicity:**

Black/African American—Asian--Native American--Alaska Native--White Hispanic/Latino---Non-Hispanic---Unknown

Patient's address: _____City_____

State:_____ Zip code:_____

Preferred Pharmacy:_____Address_____Phone_____

**********For Patient's 18yrs and older**********

PATIENT'S cell #:_____ ***Consent to text & call:** **YES / NO**

PATIENT'S email: _____

***You will now get all appointment reminder texts, emails and calls.**

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Parents and/or Legal Guardian Information:

Mother's full name:_____Cell#_____Consent to text/call? Yes/No

Father's full name:_____Cell#_____ Consent to text/call? Yes/No

***Mother's Email:_____*Father's Email:_____**

***HIPAA alert-your parent may get an email notification about your upcoming appointments.**

Other legal guardian:_____Cell#_____Relationship:_____

Emergency Contact Name:_____Cell#_____Relationship;_____

Person responsible for outstanding balances:_____

Address (if different from the patient's): _____

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Insurance information *PLEASE PRESENT INSURANCE CARDS FOR SCANNING*

Primary Insurance: _____**Member ID:**_____

Name of Policy Holder: _____**DOB:** _____**Group #:**_____

Secondary Insurance:_____ **Member ID:**_____

Name of Policy Holder:_____**DOB:**_____**Group#:**_____

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PLEASE READ AND SIGN

Assignment of Benefits:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for any non-covered services, co-pays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process my claims.
- A fee for no shows or late cancellations may apply.

Signature :_____Relationship to patient: _____Date:_____

Parents of minor children:

By law, **any child under the age of 18 years old** cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have **written permission from the parent or legal guardian** that this person has been appointed by you to act on your behalf. Please sign below to indicate you have read and understood this requirement.

X_____ _____ _____

Parent or Legal Guardian Relationship to patient Date