Premiere Pediatrics

REGISTRATION FORM

PATIENT INFORMATION

Patient name: ______________________________
(Last) (First) (Middle)

Date of birth: ____________ Male or Female SS#: ____________

Address: ______________________________
(Street/PO Box) (City/State) (Zip code)

Language: ____________ Ethnicity: Hispanic Non Hispanic Unknown

Race(s): ______________________________ Decline to specify

PARENT/LEGAL GUARDIAN

Mother: ______________________________ Date of Birth: ____________
Parent/Legal Guardian

Phone number: ____________ **TEXT:** YES NO SS#: ____________
CIRCLE

Address: ______________________________
(Street/PO Box) (City/State) (Zip code)

Father: ______________________________ Date of Birth: ____________
Parent/Legal Guardian

Phone number: ____________ **TEXT:** YES NO SS#: ____________
CIRCLE

Address: ______________________________
(Street/PO Box) (City/State) (Zip code)

Child's Medical Provider: ______________________________

Child lives with (please specify) Mother Father Other: ____________

Siblings residing in home: ______________________________

PREFFERED CONTACT METHODS

Preferred Contact Name: ______________________________

Phone number: ____________ **TEXT:** YES NO
CIRCLE

Receipts/Patient Portal: Email: ______________________________

Emergency Contact Name (other than parent): ____________ Relation: ____________

Emergency contact Phone#: ____________

The indicated emergency contact has permission for emergency medical information only.

PRIMARY INSURANCE

Primary Insurance Name & phone #: ______________________________

Claims address: ______________________________

____

Member ID: ____________ Group#: ____________

Who carries this insurance: ____________ Relation to patient: ____________

Carrier's SS#: ____________ Phone#: ____________

SECONDARY INSURANCE

Secondary Insurance Name & phone #: ____________________

Claims address: ____________________

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Member ID: ____________________ Group#: ____________________

Who carries this insurance: ____________________ Relation to patient: ____________________

Carrier's SS#: ____________________ Phone#: ____________________

RELEASE OF INFORMATION

I understand that I am giving the following person(s) permission to schedule, bring in and have access to medical and/or financial information **ONLY** for the dates they accompany my child(ren).

****Individuals listed may be granted access to specific financial and/or medical information* ***ONLY*** *if indicated below.*

Name: ____________________ Relation to patient: ____________________

Phone#: ____________________ **ADDITIONAL INFO TO BE RELEASED:** ____________________

Name: ____________________ Relation to patient: ____________________

Phone#: ____________________ **ADDITIONAL INFO TO BE RELEASED:** ____________________

Name: ____________________ Relation to patient: ____________________

Phone#: ____________________ **ADDITIONAL INFO TO BE RELEASED:** ____________________

PLEASE READ CAREFULLY AND INITIAL

________ I understand the above release will stay in effect until a change is requested in writing. I understand both biological parents have access to full disclosure (even non-custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. If those court orders exist, I must present current copies for my child's file.

________ I have reviewed and agreed to the Financial Policy, which states that I am financially responsible for any balance not covered by my insurance carrier. I understand that my coverage is determined by an agreement I have made with my insurance carrier and that insurance denials do not reflect the opinions of Premiere Pediatrics. **I am aware that if my child has sick symptoms during a wellness exam, a separate visit may be billed and copays and/or deductibles may apply, as determined by my insurance plan.**

________ I have been provided the office policies. I understand that I may receive additional copies of any policy upon request.

________ I understand that my insurance card, and photo id are required at the check-in window as well as any copay and/or past due balance past due on my account.

________ I understand that a fee may be assessed for missed appointments, and dismissal may be considered for high missed appointment volume, as per office policy.

________ I am aware that appointment wait times may vary.

I have read and agree to the policies of Premiere Pediatrics. I consent to the treatment of my child as well as the use and disclosure of my child's PHI(Protected Health Information) to carry out TPO(Third Party Operations) as outlined in our office Privacy Policy. I attest the information I have provided is true and correct.

Signature of Parent/ Legal Guardian: ____________________ Date: ____________________