PEDIATRIC PARTNERS, LLC - HOAGIE DRIVE

Patient Registration for Patients 18 Years of Age & Older
2020

Patient Name: ____________________________ **Date of Birth:** ________________ **Sex:** ________
Legal Last, First, MI – Also what you llike to be called.

Patient Social Security Number: ____

Address: ____

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Street or P.O. Box, City, State & Zip

Phone number you want to be contact at (Primary): ____________________________
Cell Phone Number: ____
Patient Work Phone: ____
Patient Email: ____________________________ **Work Email:** ________________________

Primary language spoken in the home? ____________________________________
Ethnicity: (Circle one) Hispanic Non-Hispanic Decline to Answer
Race: (Circle all that apply) American Indian Asian Black Hawaiian Native White Decline to Answer

Privacy Constraints (Check One):
______ No Restrictions: Okay to leave message/send mail.
______ Restrictions: Person to person with patient only.
______ Restrictions: ____

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

Recall: Home Address / Home Phone / Work Phone / Cell Phone / Home Email
General Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email
Patient Portal: Cell Phone / Home Email / Work Email
Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Billing statements sent to:
Name: ____________________________ Social Security Number: ____________________
Relationship to Patient: ____
Address if different than patient address: ____________________________________

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Primary Phone Number: ____________________ Cell Phone Number: ________________

Parent 1: Name: ______________________________ Date of Birth: ______________
Social Security Number: ______________________________
Work Phone: ______________________ Cell Phone: ______________________
Parent's Email: ______________________ Work Email: ______________________
Employer: ______________________________
Do you live with this parent (circle one)? Yes No Relationship to Patient: ______________
Address if different than patient: ______________________________

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Parent 2: Name: ______________________________ Date of Birth: ______________
Social Security Number: ______________________________
Work Phone: ______________________ Cell Phone: ______________________
Parent's Email: ______________________ Work Email: ______________________
Employer: ______________________________
Do you live with this parent (circle one)? Yes No Relationship to Patient: ______________
Address if different than patient: ______________________________

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Primary Insurance: ______________________________
Policy Holder's Last Name: ______________________________
Policy Holder's First Name & Middle Initial: ______________________________
Policy Holder's Date of Birth: ______________ Social Security #: ______________
Policy ID #: ______________ Policy Group #: ______________ Copay: ______
Secondary Insurance: ______________________________
Policy Holder's Last Name: ______________________________
Policy Holder's First Name & Middle Initial: ______________________________
Policy Holder's Date of Birth: ______________ Social Security #: ______________
Policy ID#: ______________ Policy Group #: ______________ Copay: ______

I authorize the release of any medical or other information necessary to process claims from PEDIATRIC PARTNERS, LLC. I also request payment of government benefits either to myself or to the party who accept assignment below. I fully understand that I am financially responsible for all charges and balances remaining from claims, including charges not covered or denied by my insurance. I have been offered a copy of the Notice of Privacy Practice (HIPPA).

______________________________ ______________________________

Signature (Must be patient if 18 or older) **Date**