PEDIATRIC PARTNERS, LLC – HOAGIE DRIVE

Patient Registration - 2020

Child's Name: _____ **Date of Birth:** _____ **Sex:** _____

Legal Last, First, MI – Also what they like to be called.

Child's Name: _____ **Date of Birth:** _____ **Sex:** _____

Child's Name: _____ **Date of Birth:** _____ **Sex:** _____

Child's Name: _____ **Date of Birth:** _____ **Sex:** _____

Child's Name: _____ **Date of Birth:** _____ **Sex:** _____

Address: _____

_____

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

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

Phone number you want to be contacted at (Primary): _____

Cell: _____

Parent 1: Name: _____ Date of Birth: _____

Social Security Number: _____

Work Phone: _____ Cell Phone: _____

Parent's Email: _____ Work Email: _____

Employer: _____

Lives with patient (circle one)? Yes No Relationship to Patient: _____

Address if different than patient: _____

_____

Parent 2: Name: _____ Date of Birth: _____

Social Security Number: _____

Work Phone: _____ Cell Phone: _____

Parent's Email: _____ Work Email: _____

Employer: _____

Lives with patient (circle one)? Yes No Relationship to Patient: _____

Address if different than patient: _____

_____

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: _____

Billing statements sent to:

Name: _____ Social Security #: _____

Relationship to Patient: _____

Address: _____

Primary Phone#: _____ Cell Phone #: _____

Privacy Constraints (Check One):

_____ No Restrictions: Okay to leave message/send mail.

_____ Restrictions: Person to person with patient/guardian 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

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.

_____

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 **Date**