Today's Date: _____/_____/_____

PATIENT REGISTRATION

Patient's Full Name_____ Sex M F Date of Birth_____

Patient's Address_____

Race (Circle) Asian Black Middle-eastern Native Other Pacific Islander White Circle One Hispanic/Not Hispanic

Language_____ Social Security #_____/_____/_____ School_____

Preferred Pharmacy_____ Current Grade_____

GUARANTOR/BILLING INFORMATION

Parent #1_____ Sex M F DOB_____ SS#_____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Employer Address _____ EMAIL _____

Parent #2_____ Sex M F DOB_____ SS#_____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Employer Address _____ EMAIL _____

Sibling's Name(s)_____

_____

INSURANCE INFORMATION

Primary Insurance Company_____ Effective Date_____

Insured Employer_____ Insured Name_____

Insured's Relationship To Patient_____ Insured DOB_____

Secondary Insurance Company_____ Effective Date_____

Insured Employer_____ Insured Name_____

Insured's Relationship To Patient_____ Insured DOB_____

ADDITIONAL AUTHORIZATION OF PATIENT'S MEDICAL RECORDS

I authorize the following individuals to act as appointed healthcare representative with whom my child's health information may be discussed. Please list the individuals below (grandmother, aunt, brother, etc.), other than the guardian/guarantor, who may obtain access to your child's medical records if needed.

- If the guardian of this patient is not allowed access to the patient's medical records, court documents stating this will need to be attached to this form.

Emergency Contact_____ Phone #_____ Relationship to patient_____

Emergency Contact_____ Phone #_____ Relationship to patient_____

Emergency Contact_____ Phone #_____ Relationship to patient_____

AUTHORIZATION AND CONSENT FOR TREATMENT, RELEASE OF INFORMATION, ACKNOWLEDGEMENT OF CLINIC PRIVACY PRACTIVES AND FINANCIAL POLICY

I hereby give consent to the providers of The Pediatric Clinic to perform examination, diagnostic testing, and treatment for my child.

I hereby authorize The Pediatric Clinic to the following:

- Furnish any medical records and information necessary to other facilities regarding my child's illness and treatment.
- To furnish my health insurance company all the information requested concerning treatment for my dependent(s) or myself.
- Assign the medical and/or surgical benefits to which my dependent(s) or I are entitles to under my health insurance plan.

I agree to pay The Pediatric Clinic for the following:

- Any payments, which are my responsibility.
- Any additional charges related to the cost of collection (including, but not limited to, collection agency fees, reasonably attorney fees, and court cost) in the event that I fail to pay my bill.

I have received and/or reviewed a copy of The Pediatric Clinic's Notice of Privacy Practices, Immunization Policy and Financial Policy.

BY SIGNING BELOW AS THE GUARANTOR, YOU AGREE TO THE ABOVE STATEMENTS

_____ _____

Signature of legal guardian/Guarantor Date