



Today's Date: ____/____/____

NEW PATIENT REGISTRATION

Please email information to info@thepediatric.com or fax to 501.819.6171. If you have any question give us a call at 501.758.1530

Patient's Full Name _____ Sex M F Date of Birth _____

Patient's Address _____

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

Language _____ Social Security # _____ School _____

Preferred Pharmacy _____ Current Grade _____

GUARANTOR/BILLING INFORMATION

Parent #1 _____ Sex ____ DOB _____ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Employer Address _____ EMAIL _____

Parent #2 _____ Sex ____ 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 PRACTICES 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 entitled 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