PEDIATRIC HEALTHCARE, LLC
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PATIENT REGISTRATION FORM

(PLEASE PRINT ALL INFORMATION)

My Primary Care Physician is Dr. _____ Date: _____

PATIENT INFORMATION:

Patient's Legal Name: _____ Goes By: _____

Patient's Date of Birth: _____ Gender: O M O F Religion _____

Name of Child's Brothers and Sisters: _____

_____

PARENT INFORMATION: **FAMILY E-MAIL ADDRESS:** _____

Mother's Name: _____ (O Mom O Step-Mom O Legal Guardian) Goes By: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____ SS#: _____ Marital Status: O Married O Single O Divorced O Widowed

Employer: _____ Occupation: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

Father's Name: _____ (O Dad O Step-Dad O Legal Guardian) Goes By: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____ SS#: _____ Marital Status: O Married O Single O Divorced O Widowed

Employer: _____ Occupation: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

Financially Responsible: _____ Relationship: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____ SS#: _____

_____

EMERGENCY CONTACT (other than parents):

Name: _____ Daytime Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Due to the HIPAA (Health Insurance Portability and Accountability Act of 1966) Privacy Regulations, Pediatric Healthcare needs to know to whom we are authorized to release your child's protected health information (PHI).

☐ Check here if we are authorized to leave information on your answering machine or voicemail.

Pediatric Healthcare is authorized to release the protected health information of my children to those listed below. I understand that I may change this in writing at any time.

_____

_____

My signature authorizes payment of health insurance benefits for covered services rendered directly to the listed physician. I further understand that I am responsible for all charges not covered by my health insurance. I give permission to the above physician and their employees to provide the requested and necessary care to my child.

Guarantor's Signature: _____ **Relationship to Patient:** _____

Witness: _____ **Date:** _____