



# Patient Registration Form | 2021

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## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Hispanic YES NO  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Text messages Yes ( ) No ( )  
Email: \_\_\_\_\_ Patient Portal Yes ( ) No ( )  
Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

## Parent/Guardian Information

**Parent A** First/ Last Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Single ( ) Married ( ) Divorced ( )  
Cell # \_\_\_\_\_ Employer: \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

**Parent B** First/Last Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Single ( ) Married ( ) Divorced ( )  
Cell # \_\_\_\_\_ Employer: \_\_\_\_\_ Work # \_\_\_\_\_

## Insurance Information

**Primary Insurance Carrier:** \_\_\_\_\_

**Policy ID#** \_\_\_\_\_ **Group/Acct #** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Policy Holder SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_

**Policy ID#** \_\_\_\_\_ **Group/Acct #** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Policy Holder SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ TRANSFERRED FROM: \_\_\_\_\_

## ABC Pediatrics Disclosures and Consents

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**Assignment of Insurance Benefits:**

I, hereby authorize direct payment of my insurance benefits to ABC Pediatrics or the physician individually to services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefits. I understand and agree that I will be responsible for any co-pay or balance due that ABC Pediatrics is unable to collect from my insurance carrier for whatever reason.

**Responsible Parties Signature:** \_\_\_\_\_

**Authorization for Text Reminders & Patient Portal:**

I hereby authorize ABC Pediatrics to send me reminder messages to my cell phone \_\_\_\_\_

I hereby authorize ABC Pediatrics to send invite for patient portal to my email \_\_\_\_\_

I understand I will need to utilize Patient portal for medication refills.

**Responsible Parties Signature:** \_\_\_\_\_

**Medicaid insurance benefits (if applicable):**

I certify that information given by me in applying for payment under these programs is correct. I authorize that release of any of my or my dependents records that these programs may request. I hereby direct that payment of me or my dependents authorized benefits be made directly to ABC Pediatrics or the physician on my behalf.

**Responsible Parties Signature:** \_\_\_\_\_

**Authorization to release non-public personal information:**

I certify that I have received and read a copy of the ABC Pediatrics Patient Information Privacy Policy. I hereby authorize ABC Pediatrics or the physician individually to release any of me or my dependents medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

**Responsible Parties Signature:** \_\_\_\_\_

**Lab/X-ray/Diagnostic Services:**

I understand that I may receive a separate bill if my medical care includes lab, X-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

**Responsible Parties Signature:** \_\_\_\_\_

**Consent to treatment:**

I hereby consent to evaluation, testing, and treatment as directed by my ABC Pediatrics physician or his or her designee. I understand that diagnosis or treatment by ABC Pediatrics may be conditional upon my consent as evidenced by my signature on this document.

**Responsible Parties Signature:** \_\_\_\_\_

**Consent for Contact:**

I authorize ABC Pediatrics to contact me VIA Home Phone, Cell Phone, Work Phone, Mail, Text or Patient Portal. Please cross out any not authorized.

**Responsible Parties Signature:** \_\_\_\_\_

**I certify that I have received and reviewed a copy of ABC Pediatrics privacy & financial policies. I understand that I have the right to revoke this consent in writing, at any time except in the extent that ABC Pediatrics has taken action in reliance on this consent. I permit a copy of this authorization be used in place of the original.**

**Responsible Party Printed Name:** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_