



Patient Registration Form | 2020

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Patient Information

Last Name: _____ First Name: _____ M.I. _____
D.O.B. _____ SS# _____ M () F () Race: _____ Hispanic YES NO
Address: _____ City: _____ State _____ Zip _____
Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____
Sibling: _____ D.O.B. _____ Registering with ABC? YES NO
Sibling: _____ D.O.B. _____ Registering with ABC? YES NO

Parent/Guardian Information

Parent A First/ Last Name: _____ D.O.B. _____
SS# _____ - _____ - _____ Single _____ Married _____ (Maiden Name _____) Divorced _____
Cell # _____ Employer: _____ Work #(____) _____

Parent B First/Last Name: _____ D.O.B. _____
SS# _____ - _____ - _____ Single _____ Married _____ Divorced _____
Cell # _____ Employer: _____ Work # _____

Emergency Contact Name: _____ Relation _____ Phone _____

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 _____

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 channels chosen below:

Home Phone () Cell Phone () Work Phone () Mail () Email () Fax ()

Responsible Parties Signature: _____

I certify that I have received and reviewed a copy of ABC Pediatrics privacy policy. 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: _____