ABC Pediatrics

Patient Registration Form | 2019

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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:_____