

ABC PEDIATRIC GROUP

Patient Registration Form



Patient Information

Last Name: _____ First Name: _____ Middle Initial: __ DOB _____ Male_ Female _
 Primary Insurance : _____ Policy ID#: _____ Group#: _____
 Secondary Insurance : _____ Policy ID#: _____ Group#: _____
 Last Name: _____ First Name: _____ Middle Initial: __ DOB _____ Male_ Female _
 Primary Insurance : _____ Policy ID#: _____ Group#: _____
 Secondary Insurance : _____ Policy ID#: _____ Group#: _____
 Last Name: _____ First Name: _____ Middle Initial: __ DOB _____ Male_ Female _
 Primary Insurance : _____ Policy ID#: _____ Group#: _____
 Secondary Insurance : _____ Policy ID#: _____ Group#: _____
 Race: _____ Primary Language _____ Cell Phone Number: _____ (voicemail Y /N)
 Home Address _____ City: _____ State _____ : Zip: _____
 Patients live with: both parents - mom - dad - Other: _____
 Email: _____ (primary email to be used to contact you)

Parent(s) / Legal Guardian Information

Select __ Mother __ Father ____ Other _____

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Email _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone Number: Cell: _____ Work: _____ Employer _____

Select __ Mother __ Father ____ Other _____

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Email _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone Number: Cell: _____ Work: _____ Employer _____

Emergency contacts

Name: _____ Relationship to patient: _____
 Phone Number: Home/Cell: _____ Work: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Please sign below that you have been offered the HIPAA Notice or an opportunity to review a copy of our HIPAA Notice. You are entitled to a personal copy of the notice at any time to keep for your records.

Signature Responsible Party: _____ Date: _____

AUTHORIZATION TO MAIL, CALL, EMAIL, TEXT and Patient Portal:

I understand the privacy risks of the mail, phone calls, emails, text messages and the Patient Portal. I authorize ABC Pediatric Group staff to communicate with me by these means including but not limited to appointment reminders, billing, referral arrangements, prescriptions, medical records and test results. I have the right to rescind this authorization at any time in writing.

Signature Responsible Party: _____ Date: _____

CONSENT The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to ABC PEDIATRIC GROUP, P.C. (the "Group"). I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Group and/or the insurance company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

Print Responsible Party Name: _____ Date: _____

Signature _____ Relationship to patient _____