GULF COAST ABC PEDIATRICS, Inc.

Patient Registration

Child 1: *Last Name:* _______________________ *First Name:* ___________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* ___________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White/Other

Child 2: *Last Name:* _______________________ *First Name:* ___________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* ___________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 3: *Last Name:* _______________________ *First Name:* ___________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* ___________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 4: *Last Name:* _______________________ *First Name:* ___________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* ___________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address:

____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (______) ________ - ___________

Who lives at this household? (Circle) Mother Father Siblings List other__________________________

Insurance:

Primary Policy: *Policy Holder's Name*: ____

Policy Holder's Birth Date: ____________________ *Policy Holder's Sex:* Male / Female

Insurance Carrier: ____

ID# ____ *Group #* ___________________________

SS#______________________________________ Patient Relationship to insured_____________________

Secondary Policy: *Policy Holder's Name*: ____

Policy Holder's Birth Date: ____________________ *Policy Holder's SSN:* ______________

Insurance Carrier: ____

ID# ____ *Group #* ___________________________

SS#_________________________________

(Circle one) **Mother / Father/ Legal Guardian** *Name*: ____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) ______ - ___________ *Cell Phone*: (____) ______ - ___________

Home Email: _______________________________ *Work Email:* ________________________________

Employer: _________________________________ *Occupation:* ________________________________

How would you ideally prefer to be contacted regarding (**MUST CIRCLE ONE**):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

*Billing Statements (**MUST CIRCLE ONE**):* Home Address / Home e-mail / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email

(Circle one) **Mother/ Father/ Legal Guardian** *Name*: ____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) ______ - ___________ *Cell Phone*: (____) ______ - ___________

Home Email: _______________________________ *Work Email:* ________________________________

Employer: _________________________________ *Occupation:* ________________________________

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here: ____

____

Additional Contact Questions:

Who should receive billing statements? **(Must answer)**____

May all contacts have access to the patient's records electronically? Yes / No / __________

If parents are divorced or separated please fill out this section:
Who has custody? ____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

____

Emergency Contacts, <u>other than parents</u>: Name & Relationship

1: ____ *Phone*: (______) ________ - ___________

2: ____ *Phone*: (______) ________ - ___________

Gulf Coast ABC Pediatrics, Inc.

I authorize the following people to seek medical attention for my children or wards at you office:

______________________________ ______________________________________

______________________________ ______________________________________

______________________________ ______________________________________

______________________________ ______________________________________

I am fully aware that a cell phone is not a secure and private line.

Can confidential messages be left on you telephone/ cell phone answering machine? Yes____ No____

I understand I am fully responsible for notifying your staff of any changes of information on the patient registration forms.

By signing this, I hereby acknowledge ABC Gulf Coast Pediatrics has the right to use and disclose protected health information for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices for Protected Health Information*. I understand I have the right to restrict how protected health information is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

____________________________________ __________________________
Signature Date

I hereby authorize the release of any medical information necessary to process insurance claims. I recognize that current, valid insurance information is necessary for reimbursement. I understand that charges **not covered** by Medicaid or Managed Care will be the patient's responsibility. I verify this information is true and accurate as of the below indicated date.

____________________________________ __________________________
Signature Date