The Children's Doctors, P.C. Patient Registration Form

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION

Patient (Legal) Last Name	**First Name (Legal)**	**Full Middle Name**	**Preferred Name**

Date of Birth	**Social Security Number**	**Gender**	**Preferred Language**
________/________/__________	________ - _______ - ___________	☐ Female ☐ Male	

Address (Number, Street, Apt#)	**City**	**State**	**Zip Code**	**County**

Race	**Ethnicity**	**Mother's Maiden Name**	**Birth Place** (Hospital, City, State)
	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown		

Siblings	**Who does child live with** (Mother, Father, Grandparents, etc)

COMPLETE IF PATIENT IS 0-17 YEARS OF AGE:

Mother / Legal Guardian	**Relationship to Patient**

Date of Birth	**Social Security Number**
________/________/__________	________ - _______ - ___________

Address (if different from above) Number, Street, Apt #

City	**State**	**Zip**

Home Phone #	**Cell Phone #**
( ) -	( ) -

Email Address

Employer	**Work Phone #**
	( ) -

Father / Legal Guardian	**Relationship to Patient**

Date of Birth	**Social Security Number**
________/________/__________	________ - _______ - ___________

Address (if different from above) Number, Street, Apt #

City	**State**	**Zip**

Home Phone #	**Cell Phone #**
( ) -	( ) -

Email Address

Employer	**Work Phone #**
	( ) -

Parent's Marital Status (circle)

Married Widowed Divorced Single Legally Separated Other: ___________________________________

WHO MAY BRING PATIENT FOR APPOINTMENTS?

As legal guardian/custodian/representative of the patient listed above I authorize the following person(s) to obtain medical treatment (including immunizations) from The Children's Doctors, P.C.

Name of Authorized Person	**Relationship to Patient**	**Name of Authorized Person**	**Relationship to Patient**

CONFIDENTIAL COMMUNICATION PREFERENCE

I consent and authorize The Children's Doctors, P.C. to use my information to contact me and/or leave a detailed message on an answering machine (e.g., referral appointments, billing or payment information, treatment information, lab results, x-ray, and other test results).

☐ Yes Initials:_________ ☐ No, Contact me by: ____ Initials:_________

I consent and authorize The Children's Doctors, P.C. to disclose verbally treatment and/or other information pertinent to my healthcare and/or payment for my healthcare, to the following specified person(s) who are at least 18 years or older.

Name of Authorized Person	**Relationship to Patient**	**Name of Authorized Person**	**Relationship to Patient**

- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this authorization at any time by notifying The Children's Doctors, P.C. in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by The Children's Doctors, P.C. before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

____ _______________________

Signature of Patient or Patient's Legal Guardian *Date*

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Patient (Legal) Last Name	First Name (Legal)	Middle Initial	Date of Birth
			________/________ /___________

EMERGENCY CONTACTS

Whom shall we contact outside the home in case of emergency?

Name	Phone #	Relationship to Patient
	( ) -	
	( ) -	
	( ) -	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	SUBSCRIBER ID/MEMBER ID	
Name of Policy Holder	**Policy Holder's Date of Birth**	**Patient's Relationship to Insured**

SECONDARY INSURANCE NAME	SUBSCRIBER ID/MEMBER ID	
Name of Policy Holder	**Policy Holder's Date of Birth**	**Patient's Relationship to Insured**

VACCINES FOR CHILDREN PROGRAM PATIENT ELIGIBILTY SCREENING RECORD

The Children's Doctors, P.C. participates in Vaccine for Children Program (VFC). If you meet the requirements of this program, we can provide your child's immunizations at a reduced fee. In order to determine eligibility we must know if your child has insurance that pays for vaccinations.

A record must be kept in the healthcare provider's office that reflects the status of all children under 18 years of age or younger, who receive immunizations through the VFC program. The record may be completed by the parent, guardian or individual of record, or by the healthcare provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

INSURANCE COVERAGE (Check statement that applies)

☐ My child has insurance that pays for vaccinations.

☐ My child has insurance, but I do not know if it pays for vaccinations. I will contact my insurance company to find out if it pays for vaccinations.

VFC PROGRAM (My child qualifies for vaccination through the VFC program because he/she (check only one box)

☐ is enrolled in Medicaid ☐ does not have health insurance ☐ is American Indian or Alaskan Native

☐ has health insurance that ***does not*** pay for vaccinations ☐ is enrolled in PeachCare for Kids

RELEASE OF AUTHORIZATION / ASSIGNMENT OF BENEFITS [must read, sign, and date]

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree to a photocopy of this form may be used in place of the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand I am financially responsible for all charges not covered by Medicaid.

____ _________________________ ____________________

Signature of Patient or Patient's Legal Guardian *Relationship to Patient* *Date*