

# Patient Registration (Pediatric)

## Patient Information

Date \_\_\_\_\_ Chart No. Patient \_\_\_\_\_ Sex:  M  F DoB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ DoB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Father/Guardian \_\_\_\_\_ DoB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Sibling \_\_\_\_\_ Sex:  M  F DoB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_Sibling \_\_\_\_\_ Sex:  M  F DoB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_Sibling \_\_\_\_\_ Sex:  M  F DoB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_Children live with:  Mother  Father  Guardian \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Party Responsible for Payment of Medical Services:  Father  Mother  Guardian  Both \_\_\_\_\_How did you hear about our practice?  Referral \_\_\_\_\_ Friend/Family  Phone Directory  Internet  Newspaper  Magazine  Other \_\_\_\_\_

## Insurance Information

Primary \_\_\_\_\_ Claims Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Co-payment \$ \_\_\_\_\_

Secondary \_\_\_\_\_ Claims Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Co-payment \$ \_\_\_\_\_

Name of Insured \_\_\_\_\_ DoB \_\_\_/\_\_\_/\_\_\_ Relation \_\_\_\_\_

Medicaid/Champus/Other \_\_\_\_\_ Current Card # \_\_\_\_\_

Physician Listed on Card \_\_\_\_\_ Phone \_\_\_\_\_

## Authorization of Treatment and Assignment of Benefit

I authorize Dr. Alex El-Sabbagh to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to \_\_\_\_\_ for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: \_\_\_\_\_

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

Witness' signature \_\_\_\_\_ Date \_\_\_\_\_

 I prefer to do my own insurance filing. Signed \_\_\_\_\_ Date \_\_\_\_\_

## HIPPA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.

Please complete the following so that we may contact you properly and securely.

• Please list the family members, or other persons, if any,

whom we may inform about your child's general

medical condition and diagnoses (including treatment,

payment and health care operations).

• Please list the family members or significant others,

if any, whom we may inform about your child's medical

condition ONLY IN AN EMERGENCY.

• Please print the address of where you would like your

billing statements and / or correspondence from our office

to be sent if other than your home.

• Please print the telephone number where you want

to receive calls about your appointments, lab and

X-ray results, or other health care information if other

than your home telephone number.

*Please be aware that a cell phone is not a secure and private line.*

• Please indicate if you want all correspondence from our

office sent in a sealed envelope marked "CONFIDENTIAL".

Yes  No

• Can confidential messages (i.e., appointment reminders) be

left on your telephone answering machine or voicemail?

Yes  No

PATIENT NAME *print* (Parent / Guardian, if under 18 years)

Date

PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Notes

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