ABC PEDIATRIC GROUP

Patient Registration Form

Patient Information

Last Name: _____First Name: _____Middle Initial: ____ DOB _____

Male__ Female __ Email:_____ (primary email to contact you)

Race: _____ Primary Language _____ Cell Number: _____

Home Address _____City: _____ State_____: Zip: _____

Patient lives with: Both Parents_____ Mom _____ Dad _____ Other: _____

Parent(s) / Legal Guardian Information

Select your relationship ____ Mother ____ Father ____ Other: _____

Last Name: _____First Name:_____ MI: ____ Date of Birth: _____

Email _____ Ph. Home/Cell: _____

Address:_____ City:_____ State: ____Zip: _____

Occupation _____Employer _____

Select your relationship ____ Mother ____ Father ____ Other: _____

Last Name: _____First Name:_____ MI: ____ Date of Birth: _____

Email _____ Ph. Home/Cell: _____

Address:_____ City:_____ State: ____Zip: _____

Occupation _____Employer _____

***********Insurance Information: Give insurance card(s) to front desk**********

Emergency contact

Name: _____ Relationship to patient: _____

Phone Number: Cell: _____Work: _____Other:_____

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 mail, phone calls, emails, text messages and Patient Portals. 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**_____