Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:

First Name:

Middle Name:

Address:

City: State:

Zip:

Home Phone:

Sex:

DOB:

Family Information

Home Phone:

Mobile Phone:

Primary Email:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Mobile Phone / Home Phone / Work Phone / Portal / Email

Consent to Receive Text Messages: Yes / No

Primary Insurance Information

Insurance Plan Name:

Last Name

First Name:

Middle Name:

Address:

City: State: Zip:

Date of Birth: Sex (please circle): **M** or **F**

SSN:

Patient's relationship to policy holder:

Guarantor Information (to whom statements are sent)

Name:

Address:

Relationship to Patient: _____

Date of Birth:

Phone: ( ) _____ - _____

Other Legal Guardian / Emergency Contact

Name:

Relationship:

Phone:

16+ Patients

Email:

Pharmacy Information:

Name:

Crossroads:

Phone:

Secondary Insurance Information

Insurance Plan Name:

Last Name:

First Name:

Middle Name:

Address:

City: State: Zip:

Date of Birth: Sex (please circle): **M** or **F**

SSN:

Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ Date:_____

****Please initial each item below and then sign and date at bottom****

Patient Name:
Patient ID:
Patient DOB:

ACKNOWLEDGEMENT AND AUTHORIZATIONS:

- **I have read and understand the HIPAA/Privacy Policy for Pediatric Physicians, PC** **Initial** _____
- **I hereby assign my insurance benefits to be paid directly to the healthcare provider** **Initial** _____
- **I authorize Pediatric Physicians, PC to release medical information required to process my claim** **Initial** _____
- **I have read and understand the Financial Policy for Pediatric Physicians, PC** **Initial** _____
- **I authorize Pediatric Physicians, PC to obtain/have access to my medication history** **Initial** _____
- **I authorize my provider's office to contact me by mobile phone** **Initial** _____

Signed_____ **Date:**_____

HIPAA Privacy and Release of Information Authorization

I, hereby authorize Pediatric Physicians, PC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____

Patient/Parent Printed Name Date

_____

Patient/Parent Signature