Patient Registration

Child's Last Name: _____
First Name: _____MI: _____
Sex: ☐M ☐F Nickname: _____
Date of birth:_____ Patient's SSN: _____

Primary (Billing) Address:

_____

Street City State & Zip

Phone numbers: Primary Phone Number: _____ Cell phone: _____

Primary Language spoken in the home? _____ **Ethnicity:** Hispanic ☐Yes ☐No

Race: ☐Asian ☐African American ☐Caucasian ☐Other_____

Parent 1: ☐Natural ☐Adoptive ☐Step-parent ☐Legal Guardian
Name: _____ Date of birth: _____
SSN: _____ Home Phone:_____
Work phone:_____ Cell phone:_____
Email:_____ Lives with patient? ☐Yes ☐No
Employer: _____ Occupation: _____

Parent 2: ☐Natural ☐Adoptive ☐Step-parent ☐Legal Guardian
Name: _____ Date of birth: _____
SSN: _____ Home Phone:_____
Work phone:_____ Cell phone:_____
Email:_____ Lives with patient? ☐Yes ☐No
Employer: _____ Occupation: _____

Parent(s) are: ☐Single ☐Married ☐Divorced ☐Widowed

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.

_____

Sibling Information:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Emergency Contact, <u>other than parents</u>:

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Insurance: (a copy of your current insurance cards is also required)

Primary Insurance: _____

Name of Insured: _____

ID#_____ Group # _____

Relationship to patient: _____ Effective Date: _____

Secondary Insurance:_____

Name of Insured: _____

ID#_____ Group # _____

Relationship to patient: _____ Effective Date: _____

Privacy Constraints (Check One):

☐ No restrictions: Okay to leave message / send mail.

☐ Restrictions: Person to person with patient / guardian only.

☐ Restrictions: _____

How would you ideally prefer to be contacted regarding:

Medical issues: ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email

Appointment Reminders ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email

***Recall*:** ☐Home Address ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email

Billing Statements: ☐Home Address ☐Email

General Notices: ☐Home Address ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email

***Patient Portal**:* ☐Cell Phone ☐Email

Preauthorization to Treat Minors

If a parent or legal guardian cannot be present prior to treatment of minor patient, a proxy adult (grandparent, babysitter/nanny, relative, etc.) may consent for care if listed below. Please be advised that protected health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed medical decision making.

☐I authorize Be Pediatrics and it's personnel to provide medical care to this child in my absence.

Initials_____

☐I **DO NOT** authorize Be Pediatrics to provide medical care in my absence.

Initials_____

Proxy Name:_____ Relationship to patient:_____

Proxy Name:_____ Relationship to patient:_____