ABC PEDIATRICS

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www.abcpeds.com

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's Last Name: **First** **MI**	Date of birth: Age:		Sex M or F
Preferred Name: **Preferred Pronouns:**		Gender Identity	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:
Address: City: State: Zip:	**Reminder Call:** **CALL OR TEXT** (please circle one) Home Phone: Cell Phone: **Primary number:** ☐ Home ☐ Cell		
With whom does the child reside:	Physician:		

SIBLING INFORMATION

Patient's Last name: **First:** **MI:**			Date of birth: Age:	M or F Circle one
Preferred Name: **Preferred Pronouns:**		Gender Identity		Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:	
With whom does the child reside:			Physician:	
Patient's Last name: **First:** **MI:**			Date of birth: Age:	M or F Circle one
Preferred Name: **Preferred Pronouns:**		Gender Identity:		Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:	
With whom does the child reside:			Physician:	
Patient's Last name: **First:** **MI:**			Date of birth: Age:	M or F Circle one
Preferred Name: **Preferred Pronouns:**		Gender Identity:		Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / Hawaiian / White		Preferred Language:	
With whom does the child reside:			Physician:	

CONTACT INFORMATION

Parent #1 Last Name: First: MI: Male or Female (please circle one)		Date of Birth:	Employer:
Address (if different than above):			
Home Phone:	Cell Phone:	Work Phone:	
E-Mail:			
Parent #2 Last Name: First: MI: Male or Female (please circle one)		Date of Birth:	Employer:
Address (if different than above):			
Home Phone:	Cell Phone:	Work Phone	
E-Mail:			

Emergency Contact: (Other than parents)

Last Name: First: Relation:		Home Phone: Cell Phone:	

OVER

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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 or NO

***If yes, please explain and provide a copy of any legal paperwork that supports this restriction:

_____

_____

INSURANCE

(Please give your insurance card to the receptionist.)

Primary Insurance: Subscriber's Last Name:	First:	MI:	Date of Birth:
Insurance Carrier:	Subscriber ID:		Group #:
Secondary Insurance: Subscriber's Last Name:	First:	MI:	Date of Birth:
Insurance Carrier:	Subscriber ID:		Group #:

I authorize payment of medical benefits by the insured directly to ABC Pediatrics. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services within 30 days unless a payment plan is negotiated in advance. I authorize ABC Pediatrics to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

_____ _____

Patient/Guardian signature Date

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from my family member that a HIV and Hepatitis-B (HBV) blood test will be performed.

_____ _____

Patient/Guardian signature Date

AUTHORIZATION FOR SPECIFIC CONFIDENTIAL COMMUNICATIONS

Is it ok to leave a detailed message including medical information on your voicemail? Yes _____ No _____

List Phone #: _____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to (other than *parent/guardian*):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- ☐ Medical Care/Treatment Level of Information: _____
- ☐ Billing Information
- ☐ Pick up PHI (such as prescriptions, billing statements, labs, etc.)
- ☐ Other (Specify in detail – appointments: such as date of service, type of service, level of detail to be released, origin of information, etc.)

_____

_____

This authorization shall be in force and effect and expires in 12 months or until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: ABC Pediatrics 4288 Three Mile Rd NW, Walker, MI 49534. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. 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.

_____ _____

Patient/Guardian signature Date