



Access our Patient Portal & Facebook though our website

www.abcpeds.com

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Patient's Last Name: Frist MI		Date of birth: Age:	
Ethnicity: Hispanic / Non-Hispanic / Unknown		Sex M or F	
Address: City: State: Zip:		Race: American Indian / Asian / Black / Hawaiian / White	
With whom does the child reside:		Preferred Language:	
		Reminder Call: CALL OR TEXT (please circle one)	
		Home Phone:	
		Cell Phone:	
		Primary number: <input type="checkbox"/> Home <input type="checkbox"/> Cell	
		Physician:	
SIBLING INFORMATION			
Patient's Last name:		First: MI:	
Ethnicity: Hispanic / Non-Hispanic / Unknown		Date of birth: Age:	
Race: American Indian / Asian / Black / Hawaiian / White		M or F Circle one	
With whom does the child reside:		Preferred Language:	
		Physician:	
Patient's Last name:		First: MI:	
Ethnicity: Hispanic / Non-Hispanic / Unknown		Date of birth: Age:	
Race: American Indian / Asian / Black / Hawaiian / White		M or F Circle one	
With whom does the child reside:		Preferred Language:	
		Physician:	
Patient's Last name:		First: MI:	
Ethnicity: Hispanic / Non-Hispanic / Unknown		Date of birth: Age:	
Race: American Indian / Asian / Black / Hawaiian / White		M or F Circle one	
With whom does the child reside:		Preferred Language:	
		Physician:	
CONTACT INFORMATION			
Parent #1 Last Name:		First: MI:	
Male or Female (please circle one)		Date of Birth:	
Address (if different than above):		Employer:	
Home Phone:		Cell Phone:	
E-Mail:		Work Phone:	
Parent #2 Last Name:		First: MI:	
Male or Female (please circle one)		Date of Birth:	
Address (if different than above):		Employer:	
Home Phone:		Cell Phone:	
E-Mail:		Work Phone:	
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