MY KID'S
PEDIATRICS & ADOLESCENT CARE

PATIENT REGISTRATION FORM

Please print clearly and bring to your first appointment.

PATIENT/SIBLINGS INFORMATION

Name (Last, First)	Middle/ Nickname	Date of Birth	SEX	Social Security Number	Demographics (same as below? If different, please specify)
1.			M F		Y /N
2.			M F		Y /N
3.			M F		Y /N
4.			M F		Y /N
5.			M F		Y /N

DEMOGRAPHIC INFORMATION

Ethnicity

- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Prefers not to answer

Preferred Language: _____

- ❑ Prefer not to answer

Race

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Prefer not to answer

CUSTODIAN INFORMATION

RELATION TO PATIENT: _____

Name: _____

SSN: _____

DOB: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Is this who the patient(s) live with? YES / NO

Is this the guarantor (who the bills are sent to)? YES / NO

RELATION TO PATIENT: _____

Name: _____

SSN: _____

DOB: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Is this who the patient(s) live with? YES / NO

Is this the guarantor (who the bills are sent to)? YES / NO

EMERGENCY CONTACT PERSON *(Someone other than Parents)

Name: _____ Relation to patient: _____ Phone#: _____

Patient Initial: _____(DOB:) Patient Initial: _____(DOB:)
Patient Initial: _____(DOB:) Patient Initial: _____(DOB:)

Communication Preferences *(Patient's Confidential Communication Preference)*

Contact Name: _____

Method: O Calling O Work Phone O Home Phone O Text _____
(phone number)

Email: _____

Would you like to sign up for **My Kid's Chart**, our patient portal, so you can securely view and print you child's medical record? We will e-mail you the link so you can sign up. [ ] Yes [ ] No

If yes, please provide e-mail:_____

PHARMACY INFORMATION

We will be sending e-prescriptions to your preferred pharmacy.

Preferred Pharmacy Name: _____ Pharmacy Phone #: _____

How did you hear about our practice? [ ] Friend/Family [ ] Referral [ ] Facebook [ ] Advertisement
[ ] Other_____

INSURANCE INFORMATION:

Primary Insurance Policy Holder's Name: _____ Relation to Patient:_____

Policy Holder's Date of Birth: _____/_____/_____ SSN: _____

Policy Holder's Address: _____

Primary Insurance Policy: _____
Is this a Medicaid Plan? [ ] Yes [ ] No

Insurance Policy #: _____ Group #: _____

Insurance Address: _____ Phone #: _____

Any Secondary Insurance? If yes, Plan & Policy #: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this physician/clinic to release any information required in the course of myself and/or dependent's examination or treatment. I further expressly agree & acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each & every claim to be submitted for myself and/or dependents.
AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for medical benefits that may be otherwise payable to me for services rendered. I understand that I am financially responsible for the charges not covered by my insurance.

Signature _____ Date _____

NOTICES OF PRIVACY PRACTICES (HIPAA): The U.S. Department of Health & Human Services has developed Notices of Privacy Practices for health care providers to communicate with their patients entitled, "Your Information. Your Rights. Our Responsibilities." This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

I hereby understand that this policy can be viewed on the My Kid's Pediatrics and Adolescent Care website www.mykidspediatricians.com at any time and that it is available to me upon request from My Kid's staff.

Signature _____ Date _____