

# A + PEDIATRICS

## Patient Registration

DATE:

PATIENT INFORMATION		
Last, First, MI:		SSN:
Date of Birth: / /	Age:	Male / Female (circle one)
Address:		City/State/Zip:
Phone #:		
CAREGIVER 1		
Last, First, MI:		
Date of Birth: / /		Male / Female (circle one)
SSN:		Marital Status: S / M / W / D / SEP
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Employer:		Occupation:
Relationship to Patient:		Email Address:
CAREGIVER 2		
Last, First, MI:		
Date of Birth: / /		Male / Female (circle one)
SSN:		Marital Status: S / M / W / D / SEP
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Employer:		Occupation:
Relationship to Patient:		Email Address:
Who is the Legal Guardian:		
How were you referred to our office?		
(please circle one): Yellow pages / Phone Book / Friend / Insurance / Employer / Other		
PRIMARY INSURANCE		
Primary Insurance Company:		Subscriber ID #:
Group #:		SSN:
Insured Name:		Date of Birth:
Patient Relationship to Insured:		
SECONDARY INSURANCE		
Secondary Insurance Company:		Subscriber ID #:
Group #:		SSN:
Insured Name:		Date of Birth:
Patient Relationship to Insured:		
EMERGENCY CONTACT PERSON		
Last, First, MI:		
Address:		City/State/Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone ( )

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## ASSIGNMENT OF BENEFITS

In the event that services rendered are not paid for by the responsible party, I hereby authorize payment of insurance benefits to **A+ Pediatrics** and any assisting providers for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

## CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for **A+ Pediatrics** to furnish medical care and treatment to my child \_\_\_\_\_.

I give permission for the following people to bring my child to the office:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby confirm that I have been given access to and have reviewed a copy of **A+ Pediatrics** HIPAA Notice of Privacy Practices.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date