Patient Registration Form

PLEASE PRINT YOUR ANSWERS TO THE FOLLOWING QUESTIONS

Today's Date: _________________________

PATIENT INFORMATION: (Please use full legal name, no nicknames please)
Last Name: _______________________________________ First Name: ____________________________________
Middle Initial: ______________________ SS# ____
Date of Birth: ______________________ Sex: Female [ ] Male [ ]
Name your child prefers to be called:____

PATIENT INFORMATION: (Please use full legal name, no nicknames please)
Last Name: _______________________________________ First Name: ____________________________________
Middle Initial: ______________________ SS# ____
Date of Birth: ______________________ Sex: Female [ ] Male [ ]
Name your child prefers to be called:____

PATIENT INFORMATION: (Please use full legal name, no nicknames please)
Last Name: _______________________________________ First Name: ____________________________________
Middle Initial: ______________________ SS# ____
Date of Birth: ______________________ Sex: Female [ ] Male [ ]
Name your child prefers to be called:____

****Mailing**
Address: ____

City: _______________________________________ State: _____________________________ Zip: _______________
Telephone number to best reach you through the daytime:____
Emergency Contact Name: ___________________________________ Emerg Phone #: __________________________
Parent Email address:
____
Preferred Method of Contact: [ ] Phone Call [ ] Text Message [ ] Secure Web Message (patient portal)

PARENT INFORMATION: (List person or Insured name responsible for bill – use full legal name, no nicknames please)
**Person responsible for Bill: Mother Father Other_______________________
**Mom's First & Last Name: ____DOB: _________________
Mother's Cell #:____________________________ Mother's SSN____
**Dad's First & Last Name: ____DOB:_________________
Dad's Cell #: ________________________________ Dad's SSN____
Parent Social Security Numbers are used for ordering labs and sending out referrals, all information is confidential and HIPPA protected

Other child(ren) attend the office [ ] yes [ ] no

Please continue>>>

CONSENT FOR TREATMENT:

[ ] I hereby consent to treatment for myself, my child, or minor at any office owned and operated by Children's Health of Carolina, PA.

ASSIGNMENT OF INSURANCE BENEFITS:

[ ] I hereby authorize direct payment of my insurance benefits to Children's Health of Carolina, PA for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit.

[ ] I understand and agree that I will be responsible for any co-pay or balance due to Children's Health of Carolina, PA at the time that the medical services are rendered.

[ ] I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Children's Health of Carolina, PA on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

[ ] I certify that I have received and read a copy of Children's Health of Carolina, PA Patient Information Privacy Policy. I hereby authorize Children's Health of Carolina, PA to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

[ ] I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Children's Health of Carolina, PA representative or my physician or under his/her supervision to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Children's Health of Carolina, PA to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

[ ] I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Persons that I authorize to consent to treat include: ____
__________________________________, __________________________________, ____________________________
__________________________________,__________________________________,____________________________

PATIENT SIGNATURE: ____DATE: _______________________

GUARANTOR SIGNATURE: ____DATE: _______________________
(If different from patient)
GUARANTOR NAME (Please Print):____

Witness signature:____Date:_______________________

Witness name (Please Print):____