QUAKERBRIDGE PEDIATRICS, PC

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2015 EMR PATIENT REGISTRATION FORM

ATTENTION! PLEASE FILL THIS FORM COMPLETELY FOR ELECTRONIC MEDICAL RECORD, AS IT WILL AFFECT YOUR CHILD'S HEALTH RECORD AND CARE.

PATIENT NAME: _____ D.O.B: ____/____/____ SEX: □ M □ F
LAST FIRST MIDDLE

ADDRESS: _____ CITY: _____ _____STATE: _____ ZIP: _____

ETHNICITY: □ HISPANIC/LATINO □ NON- HISPANIC/LATINO □UNKNOWN □ DECLINE TO ANSWER

RACE: □ ASIAN □ AFRICAN AMERICAN □ CAUCASIAN □ AMERICAN INDIAN/ALASKAN NATIVE
□ HAWAIIAN NATIVE/PACIFIC ISLANDER □ DECLINE TO ANSWER

PRIMARY LANGUAGE: _____

1. PARENT/GUARDIAN NAME: _____

RELATION TO PATIENT: _____

LIVES WITH PATIENT? □YES □NO

ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

D.O.B: ____/____/____

HOME PHONE: _____
CELL PHONE: _____
WORK PHONE: _____
HOME EMAIL: _____
EMPLOYER: _____

2. PARENT/GUARDIAN NAME: _____

RELATION TO PATIENT: _____

LIVES WITH PATIENT? □YES □NO

ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

D.O.B: ____/____/____

HOME PHONE: _____
CELL PHONE: _____
WORK PHONE: _____
HOME EMAIL: _____
EMPLOYER: _____

TELEPHONE NUMBER FOR MEDICAL ISSUES/APPOINTMENT REMINDER: (_____)_____

PHARMACY NAME AND NUMBER: _____ (_____)_____

IF PARENTS ARE DIVORCED OR SEPARATED PLEASE ANSWER THE FOLLOWING QUESTIONS:

WHO HAS CUSTODY OF THE PATIENT? _____

ARE THERE ANY LEGAL RESTRICTIONS THAT WOULD RESTRICT THE NON-CUSTODIAL PARENT FROM CONSENTING TO MEDICAL TREATMENT OR FROM OBTAINING INFORMATION ABOUT THE CHILD'S MEDICAL TREATMENT? □ YES □NO
IF YES, PLEASE EXPLAIN AND PROVIDE A COPY OF ANY LEGAL PAPERWORK THAT SUPPORTS THIS RESTRICTION

_____ _____
SIGNATURE: □ PARENT □ GUARDIAN DATE

FLIP PAGE

INSURANCE INFORMATION:

PRIMARY POLICY:

POLICY HOLDER'S NAME: ___ _____ D.O.B: ____/____/____ SEX: □ M □ F

INSURANCE CARRIER: _____ RELATION TO PATIENT: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

DO YOU HAVE SECONDARY INSURANCE? □ YES □NO

IF YOU HAVE SECONDARY INSURANCE, YOU MUST COMPLETE SECTION BELOW FOR COORDINATION OF BENEFITS

SECONDARY POLICY:

POLICY HOLDER'S NAME: _____ D.O.B: ____/____/____ SEX: □ M □ F

INSURANCE CARRIER: _____ RELATION TO PATIENT: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

ADDITIONAL BILLING QUESTIONS:

WHO SHOULD RECEIVE BILLING STATEMENTS? _____

LIST ADDRESS IF DIFFERENT FROM ABOVE: _____

PATIENT AUTHORIZATION

I, _____ AUTHORIZE THE FOLLOWING PEOPLE TO BRING THIS PATIENT
NAME OF: □ PARENT □ LEGAL GUARDIAN
TO THE OFFICE FOR MEDICAL CARE.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

_____ _____

SIGNATURE: □ PARENT □ GUARDIAN DATE

ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS. I ALSO UNDERSTAND PAYMENT OF MEDICAL BENEFITS TO QUAKERBRIDGE PEDIATRICS, P.C. FOR SERVICES RENDERED. I UNDERSTAND THAT IF SERVICES RENDERED ARE NOT COVERED BY MY INSURANCE COMPANY I WILL BE RESPONSIBLE FOR PAYMENT TO THE ABOVE GROUP.

_____

SIGNATURE: □ PARENT □ GUARDIAN

_____

DATE

RELEASE OF MEDICAL INFORMATION

I HEREBY GIVE PERMISSION FOR THE PHYSICIANS AND STAFF OF QUAKERBRIDGE PEDIATRICS, P.C. TO RELEASE MEDICAL INFORMATION REGARDING MY CHILD TO: A) OTHER MEDICAL CARE PROVIDERS; B) SCHOOL/CAMP NURSES; C) INSURANCE COMPANIES; AND D) PHARMACISTS AND THEIR STAFF VIA TELEPHONE, FAX, PAPER OR ELECTRONIC MEDIA.

_____

SIGNATURE: □ PARENT □ GUARDIAN

_____

DATE