PATIENT REGISTRATION

Child's Full Name _____DOB _____ Age _____

Sex: M F Languages Spoken: _____

Child's Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child'sRace: ☐ American Indian/ Alaskan Native ☐ Asian ☐ White

☐ African American ☐ Hawaiin Native/ Pacific Islander

Home Address _____City _____State _____Zip_____

Home Telephone_____Alt.Telephone_____SSN_____

Alternate Contact _____Relation to Child _____Telephone_____

Mother's Full Name_____DOB_____SSN_____

Address (if different from child)_____City _____ State _____Zip_____

Mother's Employer _____ Telephone _____

Mother's Work Address _____City _____State _____Zip _____

Mother's E-mail Address _____

Father's Full Name _____DOB_____ SSN _____

Address (if different from child) _____City _____State _____Zip_____

Father's Employer_____ Telephone _____

Father's Work Address _____ City _____State _____Zip_____

Father's E-mail Address _____

Preferred Method of Contact:

Appointment Reminders Call:	☐ home phone	☐ text to cell	☐ e-mail	☐ cell phone
Recalls:	☐ home phone	☐ text to cell	☐ e-mail	☐ cell phone
Billing Statements:	☐ home phone	☐ text to cell	☐ e-mail	☐ cell phone
General Notice:	☐ home phone	☐ text to cell	☐ e-mail	☐ cell phone
Patient Portal:	☐ home phone	☐ text to cell	☐ e-mail	☐ cell phone
Medical Issues:	☐ home phone	☐ cell phone		

Pharmacy Name: _____ Phone: _____

Siblings	Name	Age	Sex

INSURANCE INFORMATION: ( ) Self Pay ( ) Insurance ☐ **HMO** ☐ **PPO** ☐ **POS** ☐ **EPO** ☐ **Indemnity** ☐ **Medicaid**

Primary Insurance Carrier _____Employer_____

Primary Insurance Policy Holder_____DOB_____Relationship_____

Primary Insurance ID_____Group_____Effective_____

Secondary Insurance Carrier_____Employer_____

Secondary Insurance Policy Holder_____DOB_____Relationship_____

Secondary Insurance ID_____Group_____Effective_____

Assignment and Release of Information:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Pediatric Healthcare of Northwest Houston, PA all insurance benefits if any, otherwise payable to me for services rendered. I understand I am fully responsible for all charges whether paid or not by the insurance company. I hereby authorize Pediatric Healthcare of Northwest Houston, PA to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.

Notice of Privacy Practices and Consent to Use and to Disclose Protected Health Information:

Your protected health information will be used by Pediatric Healthcare of Northwest Houston, PA or disclosed to others for the purposes of treatment, obtaining payment, or supporting day-to-day healthcare operations of the practice. Pediatric Healthcare of Northwest Houston, PA reserves the right to modify the privacy practices outlined in the privacy notice. Notification will be served upon a change. I have reviewed the brochure "Notice of Privacy Policies and Practices" and give my permission to Pediatric Healthcare of Northwest Houston, PA to use and disclose my health information in accordance with this consent and the notice provided.

_____Date_____ Relationship_____

Signature of Responsible Party

Print Name_____