Registration
Pediatric

Patient Information

Date _____ Chart No. _____

Patient _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Mother/Guardian _____ DoB___/___/___ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Father/Guardian _____ DoB___/___/___ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Children live with: ☐ Mother ☐ Father ☐ Guardian _____

Emergency Contact Person _____ Relation _____ Phone _____

Party Responsible for Payment: ☐ Father ☐ Mother ☐ Guardian ☐ Both _____

Who referred you to our office? _____

Insurance Information

Primary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Secondary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Name of Insured _____ DoB___/___/___ Relation _____

Medicaid/Champus/Other _____ Current Card # _____

Physician Listed on Card _____ Phone _____

Authorization of Treatment and Assignment of Benefit

I authorize **Seashore Pediatrics** to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to **Seashore Pediatrics** for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: _____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature _____ Relationship _____ Date _____

Witness' signature _____ Date _____

☐ I prefer to do my own insurance filing. Signed _____ Date _____

HIPPA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.