Patient Registration Form

Child 1: Last Name: _____ First Name: _____ MI: _____

Date of Birth (DOB): _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Parent/Legal guardian #1:

Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ____ / ____ / ____ Social Security #: ____ - ___ - _____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Home E-mail: _____ Work E-mail: _____

Employer: _____ Occupation: _____

Main Mailing Address: _____
(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (_____) _____ - _____ Cell Phone: (____) _____ - _____

Who lives at this household? _____

Insurance Information:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____

ID# _____ Group # _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____

Insurance Carrier: _____

ID# _____ Group # _____

Preferred Pharmacy Address: _____ **Pharmacy Phone**: (_____) _____ - _____

Pharmacy Fax Number: (_____) _____ - _____

How would you prefer to be contacted regarding (circle one for each): (continue on next page)

Medical Issues: Home Phone / Work Phone / Cell Phone / Home E-mail

***Appointment Reminders**:* Home Phone / Cell Phone / Home E-mail / Work E-mail

***Recall Notices*:** Home Address / Home Phone / Work Phone / Cell Phone / Home E-mail

***Billing Statements**:* Home Address / Home E-mail / Work E-mail

***General Practice Notices**:* Home Address / Home Phone / Cell Phone / Home E-mail

***Patient Portal Notifications**:* Cell Phone / Home E-mail / Work E-mail

Parent/Legal guardian#2 Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ____ / ____ / ____ Social Security #: ____ - ___ - _____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

Do we have to notify also contact person #2 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications lists? Circle: Yes / Not

Emergency Contact, other than Parents:

Name & Relationship: _____Phone: (_____) _____ - _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No _____

If parents are divorced or separated please fill out this section:

1. Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

2. Which parent is able to provide consent about course of medical treatment and **coordination of care (not including surgery)? _____**

3. Which parent is able to provide consent about course of medical treatment **including surgery and invasive medical** procedures? _____

Medical Treatment Consent: I consent Isidro Lopez MD PA and its staff to discuss and evaluate and disclose any information related to payment, treatment and healthcare operations related to my child/children medical care, including billing questions. I understand that all protected health information will be used for the medical treatment, coordination of care, evaluation, and healthcare operational purposes related to all my child/children healthcare needs per HIPAA privacy and security regulations. I have read, understand, and agree to follow all Healthy Children policies.

Parent/Legal guardian: _____Signature: _____ Date: _____

Patient Registration Form (list additional children)

Child # 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Child # 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Child # 4: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Child # 5: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Child # 6: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White