PARTNERS 4KIDS Patient(s) Registration Form

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

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____ SSN # _____

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

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

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____ SSN # _____

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

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

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____ SSN # _____

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

MAILING ADDRESS: Please fill out City, State, and Zip Code as well. **PHYSICAL ADDRESS**: Please fill out City, State, and Zip Code as well.

CONTACT 1:	**CONTACT 2**:
Name:	Name:
Relationship to Patient:	Relationship to Patient:
Lives with Patient?	Lives with Patient?
Date of Birth:	Date of Birth:
Social Security Number:	Social Security Number:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Home Email:	Home Email:
Work Email:	Work Email:
Employer:	Employer:
Occupation:	Occupation:

***Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____**

***Place a check in front of the communication method(s) you prefer.**

___Home Phone ___Work Phone ___Cell Phone ___Home Email ___Work Email ___Mail ___Text Message

INSURANCE: PRIMARY POLICY ONLY. (PLEASE DO NOT LIST CHILD AS POLICY HOLDER)

Primary Insurance Carrier:_____ Policy Holder's Name _____

Policy Holder's Birth Date: ___/___/___ Policy Holder's SSN: _____ Policy Holder's Sex: Male / Female
ID# (Policy) _____ Group (ACCOUNT) #_____ EFFECTIVE DATE: _____

Secondary Insurance Carrier:_____ Policy Holder's Name _____

Policy Holder's Birth Date: ___/___/___ Policy Holder's SSN: _____ Policy Holder's Sex: Male / Female
ID# (Policy) _____ Group (ACCOUNT) #_____ EFFECTIVE DATE: _____

WE DO NOT BILL SECONDARY INSURANCE.

PLEASE COMPLETE BOTH SIDES OF THIS FORM. UPON COMPLETION, YOU WLL BE REQUIRED TO PROVIDE A PHOTO IS AND YOUR INSURANCE ID CARD IF APPLICABLE.

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NOTICE OF PRIVACY POLICY AND FINANCIAL POLICY: Please find in the Waiting Room a copy of our HIPAA (Privacy Policy Act) along with our Financial Policy. We will gladly provide you with a copy of our Privacy and/or Financial Policy upon your request. You can also find said policies on our website. (www.partners4kids.com)

I have read/received the Notice of Privacy Policies at Partners 4Kids.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **DATE**

CONSENT TO TREAMENT: I give my permission to the health care providers of Partners 4Kids and such assistant as they may deem necessary to provide medical services to me/my child(ren). I understand by signing this form, I am authorizing them to treat me/my child(ren) for as long as I seek care from Partners 4Kids providers, or until I withdraw my consent in writing.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **DATE**

MEDICAL CONSENT FOR MINOR(S) – in the event that a parent or legal guardian in not the presenter of said child(ren)

I, _____, parent or legal guardian of child(ren)_____

_____, do herby consent to any medical care/procedures and the administration of medications/vaccinations determined by a physician to be necessary for the welfare of my child(ren) while under the care of:

Temporary Guardian 1: _____ **Phone #: _____**

Temporary Guardian 2: _____ **Phone #: _____**

□ Please Check the Box IF YOU CONSENT to the taking and use of photographs of your child(ren)by Partners 4Kids for promotional use including but not limited to our website, Facebook Page and our VIP Wall; with the understanding that this waiver will be in effect until you provide, in writing, a cease order.

CONSENT for ELECTRONIC COMMUNICATION via EMAIL and TEXT

I, _____, hereby consent to have Partners 4Kids communicate with me where appropriate via email regarding the following aspect of my child(ren)'s medical care and treatment: (test results, prescriptions, appointments, billing, etc). I understand that email is not a confidential method of communication. I further understand that there is a risk that email communications between Partners 4Kids and I regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any email communications between Partner 4Kids and I will be made part of my child(ren)'s medical record. I understand that in an urgent situation I should Call my provider or go to the Emergency Room and not rely on email. **DO NOT SIGN IF YOU WISH NOT TO BE COMMUNICATED WITH VIA EMAIL.**

_____ _____

EMAIL **PHONE (TEXT MSGS)**

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **DATE**

NO SHOW POLICY: Every appointment I schedule is exclusively made for me. It is valuable time made by the Doctor/Provider to see me and if I am unable to make my appointment then I will call at least two (2) hours before my scheduled visit to cancel or reschedule. If my appointment is not cancelled or rescheduled, I am aware that Partners 4Kids has the right to charge me $25.oo no show fee.

PRINT NAME: _____ SIGNATURE:_____