PEDIATRIC HEALTH PARTNERS

Patient Name(s): _____

Date of Birth: _____ Sex: _____

Mother's Full Name: _____Occupation:_____

Father's Name: _____ Occupation: _____

Address: _____

Child Lives With: _____ Patient Ethnicity/ Race: _____ Decline _____

Mother's Phone: _____ Home Cell Preferred

Father's Phone: _____ Home Cell Preferred

Other Phone: _____ Work Home Cell Preferred

Email: _____

Emergency Contact (other than parents): _____

Contact's Phone Number: _____ Contact's Relationship to Patient: _____

Insurance Coverage: Yes No/Self-Pay

Insurance Company Name: _____

Policy/ ID Number: _____ Group Number: _____

Subscriber's Name (Responsible Party): _____ Subscriber's DOB: _____

Relationship to Patient: _____

Address if different from Patient: _____

Preferred Pharmacy (Include Address/Phone/Cross Street): _____

Whom may we thank for referring you? _____

Consent to Health Care

I hereby request and authorize the providers of Pediatric Health Partners, PLLC to perform any diagnostic procedures, diagnostics, and healthcare which in their professional judgement is deemed necessary to diagnose and/or treat the patient's condition and/or provide well child care. Additionally, I acknowledge that my child(ren) are being seen by a pediatric nurse practitioner at each visit.

Name Relationship to patient Date

Consent to the Treatment of Minors

I authorize the providers at Pediatric Health Partners, PLLC to provide health care to my child(ren) in my absence when accompanied by the following persons:

Name Relationship to patient

Hippa Policy

I understand that Pediatric Health Partners, PLLC is HIPAA compliant and will protect my child(ren)'s personal information.

The undersigned certifies that he/she has provided correct information in this Patient Registration Record and understands that any false statements or concealment of material may in fact be prosecuted under applicable federal and state laws.

Name Relationship to Patient Date