Medical Center Pediatrics P.L.L.C
Patient Registration Form

Patient'sName:_____M or F (circle one) DOB_____

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Patient'sName:_____M or F (circle one) DOB_____

Patient'sName:_____M or F (circle one) DOB_____

Child lives with (circle one) Both Parents, Mom, Dad, Other_____

Name of person statements are to be sent to: _____

MOTHER'S INFORMATION

Name:_____
Date of Birth:_____
Address:_____
City/State/Zip_____
Primary Phone Number:_____
Alternate Phone:_____
Email:_____
Biological Mother (circle) YES or NO

FATHER'S INFORMATION

Name_____
Date of Birth:_____
Address:_____
City/State/Zip_____
Primary Phone Number:_____
Alternate Phone:_____
Email:_____
Biological Father (circle) YES or NO

POLICY CHILD IS ON (circle): MOM DAD BOTH OTHER_____

EMERGENCY CONTACT (other than parent)

Name:_____Relationship:_____Ph#:_____

TREATMENT AUTHORIZATION

Please provide information regarding anyone that you authorize to give consent for treatment of your child and immunization authorization on your absence.

Name:_____Relationship:_____Ph#_____

Name:_____Relationship:_____Ph#_____

OVER

AUTHORIZATIONS

I hearby authorize Medical Center Pediatrics P.L.L.C physicians and/or staff to provide medical care to my minor child or children in my absence. This consent shall be voided upon written request.

I hearby authorize Medical Center Pediatrics P.L.L.C to leave any messages or send a mail that may contain medical information. This consent shall be voided upon request.

I hearby authorize Medical Center Pediatrics P.L.L.C to release medical or incidental information, for my child, at their discretion.

I certify that the above information given by me is correct.

Signature of Parent/Guardian_____Date:_____

ACKNOWLEDGEMENT OF REVIEW OF OUR PRIVACY PRACTICE NOTICE

I acknowledge that this notice of the Privacy Practices is posted in the office where I can review it if desired. I am aware that I can obtain a paper copy of this notice if requested.

Parent/Guardian:_____Date:_____

Refusal to acknowledge review of our privacy practices.

Documentation of "Good Faith Effort"

The patient presented for treatment on this date, and was given the opportunity to review the practices Privacy Notice. A good faith effort was made; the written acknowledgement was NOT obtained because:

_____Parent/Guardian refused to sign, with reason:_____

_____Parent/Guardian unable to sign due to:_____

_____There was a medical emergency preventing timely signature, and an attempt will be made to obtain acknowledgement later.
_____Other:_____

OTHER INFORMATION

Pharmacy Information:
Name:_____
Address or cross street:_____
City:_____
Phone:_____

Race: (circle any that apply)
Hispanic or Latino
Not Hispanic or Latino
- American Indian or Alaskan Native
- Asian
- Black
- Hawaiian Native or Pacific Islander
- White (non Hispanic or Latino)
- Decline to answer

Language spoken:_____