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

Full Name:_____Date of Birth _____M F Other(circle one)

Address:_____City/Zip_____

Contact Number:_____Email Address:_____

MOTHER'S INFORMATION

Name:_____
Date of Birth:_____
Address:_____
City/State/Zip_____
Primary Phone Number:_____
Alternate Phone:_____
Email:_____

FATHER'S INFORMATION

Name_____
Date of Birth:_____
Address:_____
City/State/Zip_____
Primary Phone Number:_____
Alternate Phone:_____
Email:_____

POLICY YOUARE ON (circle): SELF MOM DAD BOTH OTHER_____

Name of person statements can be sent to: _____

EMERGENCY CONTACT (other than self)

Name:_____Relationship:_____Ph#:_____

TREATMENT AUTHORIZATION

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

I hereby authorize Medical Center Pediatrics P.L.L.C to release medical or incidental information, at their discretion.

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

Signature:_____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.

Signature:_____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:

_____Patient refused to sign, with reason:_____

_____Patient 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 one)

Hispanic or Latino

None 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:_____

ADDITONAL WAIVERS

I give Medical Center Pediatrics P.L.L.C permission to discuss my medical history with the following person(s):

Name:_____Relationship:_____

Name:_____Relationship:_____

I give Medical Center Pediatrics P.L.L.C permission to discuss my financial history with the following person(s):

Name:_____Relationship:_____

Name:_____Relationship:_____