Pine Grove Pediatrics Patient Registration Form

Patient Name: _____ **Date of Birth:**___/__/_____ **Sex:** __**M** ___**F**
(Last, First, Middle) **Social Security Number:**_____
Primary Language:_____ **Race:**_____ **Ethnicity:**_____
Address where patient lives:_____
_____
Patient lives with:_____
Primary phone number:_____ **Secondary Phone number:**_____

Mother's Name: _____ Date of Birth:___/____/___
Mother's Social Security Number_____Mother's email:_____
Mother's phones: cell_____home:_____work_____
Mother's Address_____

Father's Name: _____ Date of Birth:___/___/___
Father's Social Security Number_____ Father's email:_____
Father's phones: cell_____home_____work_____
Father's Address_____

Other Guardian's Name:_____Date of Birth:____/___/____
Guardian's relationship:_____ Guardian's Social Security Number_____
Guardian's email:_____Guardian's phone: cell_____home_____work_____
Guardian's Address:_____

Name of Insurance : _____ **Card Holder Name**_____
ID Number_____ **Group Number**_____

Authorization for Medical Treatment

Both parents will be authorized to seek medical treatment for their children unless there is a court order to the contrary. Other family members and friends will not be allowed to seek treatment for your child without authorization from a parent or guardian. If you would like to authorize other family members or friends to seek medical treatment, including immunizations, for your children, you may list them below:

Name :_____Relationship_____ Phone#_____

Name :_____ Relationship _____Phone #_____

Name:_____Relationship_____Phone #_____

This privilege may be revoked at any time in writing by a parent or guardian. In addition I authorize that patient related **information may be left as messages on my (please circle) home phone, work phone, cell phone, email.**

I, _____the parent or guardian of _____have received a copy of Pine Grove Pediatrics' Notice of Privacy Practices and Financial Policy and agree to the terms. I also understand that the terms of the financial policy for Pine Grove Pediatrics and agree to the terms. I also understand that the terms of the financial policy may be amended by the practice anytime without notification to the patient.

Signature:_____**Date:**_____