Salina Pediatric Care

785 – 825 – CARE (2273)

REGISTRATION FORM

Patient Information

Patient's Last Name:	First Name:	MI:	Sex: M F
Birth Date: / /	Social Security No:	Race:	
Street Address:	City	State:	Zip	Is this New? ye no
Home Phone	Preferred Language:	Ethnicity (Please check one): ◊ Hispanic or Latino ◊ Unknown ◊ Not Hispanic or Latino ◊ Decline to answer	
Other family members seen here:			

☐ Same address as Patient — Mother/Guardian Information

Last Name:	First Name:	MI:	
Birth Date: / /	Social Security No:	Former Name if any:	
Street Address:	City	State:	Zip	Is this New? ye no
Home Phone	Cell Phone No:	Work Phone No:	May we contact you at yes no
Occupation:	Employer:		

☐ Same address as Patient — Father/Guardian Information

Last Name:	First Name:	MI:	
Birth Date: / /	Social Security No:	Former Name if any:	
Street Address:	City	State:	Zip	Is this New? ye no
Home Phone	Cell Phone No:	Work Phone No:	May we contact you at yes no
Occupation:	Employer:		

Insurance Please give your insurance card to the receptionist.

Primary Insurance:		
Subscriber ID#:	Group #:	
Group Name:	Relationship to patient:	
Subscriber Name:	Birth Date: / /	Sex: M F
Secondary Insurance:		
Subscriber ID#:	Group #:	
Group Name:	Relationship to patient:	
Subscriber Name:	Birth Date: / /	Sex: M F

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Permission to treat and release information.

E-Mail		
E-mail Address:	Would you like to receive newsletters,	yes no

The following have permission to request treatment and/or information:

Last Name:	First Name:		
Relationship to patient:	Home Phone No:		
Street Address:	City	State:	Zip
This person has permission to seek medical treatment for the above child.			yes no
This person has the permission to request & receive medical information for the above child.			yes no

Last Name:	First Name:		
Relationship to patient:	Home Phone No:		
Street Address:	City	State:	Zip
This person has permission to seek medical treatment for the above child.			yes no
This person has the permission to request & receive medical information for the above child.			yes no

Consent and Acknowledgement

All of the information on this document is true to the best of my knowledge.

Assignment of Benefits: I request that payment of authorized benefits, including Medicare, Medicaid, Medgap and all other third party services furnished to me. I authorize any hold of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand I am responsible for payment of deductibles, coinsurance and non-covered services and authorize SALINA PEDIATRIC CARE, to take such measures necessary to secure payment.

Financial Responsibility for Vaccines: I understand that my insurance may not cover certain vaccine recommended by my physician which I choose to receive. I agree to be financially responsible for the cost of such vaccines regardless of my insurance coverage.

Acknowledgement of Privacy Notice: I acknowledge that I have been offered a copy of Provider's Notice of Privacy Practices with the effective date of May 1st, 2009.

Acknowledgement of Patient rights & Responsiblities: I acknowledge that I have been offered a copy of SRHC Patient Rights & Responsiblities.

Permission to treat/request authorization: I authorize SALINA PEDIATRIC CARE to allow the above person(s) to seek medical treatment and/or information regarding my child as indicated above.

Patient/Guardian Signature

Date