Acct #_____

PAMPA
Patient Registration

Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Resides with: _____

Child 2: Last Name: _____ First Name: _____ MI: _____
D.O.B.: _____/_____/_____ Sex: _____ Resides wtih:: _____

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Resides with: _____

Contact 1: Name: _____

Relation to Patient: _____ Lives with patient?: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ___ - _____

Cell Phone: (____) _____ - _____ Phone: (____) _____ - _____(Home or Work)

Email: ____ _____Employer:_____

Mailing Address:

_____

(Street or PO Box) (City) (State & Zip)

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Cell Phone / Other Phone Appointment Reminders: Cell Phone Text or Email

Contact 2: Name: _____

Relation to Patient: _____ Lives with patient?: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ___ - _____

Cell Phone: (____) _____ - _____ Phone: (____) _____ - _____(home or work)

Email: ____ _____Employer:_____

Mailing Address if different than Contact 1:

_____

(Street or PO Box) (City) (State & Zip)

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Cell Phone / Other Phone Appointment Reminders: Cell Phone Text or Email

Additional Contact Questions:

May all contacts have access to the patient's records? Yes / No

How did you hear about our practice? _____

Friend / Neighbor / Doctor / Insurance / Website / Other _____

Please specify below if we can thank a friend for referring you!

_____

Insurance information:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ ID# _____

If parents are divorced or separated please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents: Name & Relationship

1: _____ Relationship _____ Phone: (___) _____ - _____

Financial/Privacy Policies (HIPAA)

(Initial) _____ I authorize PAMPA to treat the above-named child (children and to release medical and billing information to the insurance company so that payment for charges can be processed.

(Initial) _____ I understand that in order for PAMPA to file my insurance, I must present a valid card at the time of each visit. If no proof of insurance is provided I must pay for the services rendered at the time of service.

(Initial) _____ I authorize my children to receive health services with the understanding that if our insurance or managed care company determines that any services provided are non-covered services, I will be billed and held responsible for services rendered. Co-pays, deductibles and co-insurance amounts are due at time of service. A billing fee of $15 a month will be applied to any balance not paid at time of service. (Initial) _____ I acknowledge the Administrative Fee (ASF) is a yearly fee intended to cover the cost of certain administrative services we may provide which are not covered by your insurance.

(Initial) _____ I acknowledge the cancellation policy which states that PAMPA requires a 24-hour cancellation notice for all well child check up visits and consultations. A $25.00 fee will be assessed per child for any missed or cancelled appointments without appropriate notice. Your cancellation must be made during regular office hours. As always, emergencies and unforeseen circumstances are taken into consideration.

Insured or authorized person's signature: _____ Date _____

Printed Name: _____Relationship to child/children _____