

# Soos Pediatrics, PC

## New Patient Registration Form

<b>Child's Name: (complete the following)</b>		<b>Today's Date:</b>	
<b>First</b>	<b>Middle</b>	<b>Last</b>	<b>Sex</b>
			F    M
<b>Address</b>	<b>City</b>	<b>State/Zip Code</b>	<b>Child's SS #</b>
<b>Mother's Name:</b>		<b>DOB:</b>	<b>Social Security #:</b>
Email Address (for updates, etc.)			
<b>**Address if different from above:</b>			
<b>Home and/or Cell Phone:</b>	<b>Employer:</b>	<b>Work Phone #:</b>	
<b>Father's Name:</b>		<b>DOB:</b>	<b>Social Security #:</b>
<b>**Address if different from above:</b>			
<b>Home Phone:</b>	<b>Employer:</b>	<b>Work Phone #:</b>	
<b>If Divorced or Separated List Custodial Parent:</b>			
<b>Nearest relative not living with you; Provide phone number</b>			
<b>Who may we contact incase of an emergency? Please provide phone #</b>			
<b>MEDICAL INSURANCE INFORMATION: (Present card at Front Desk) List PRIMARY First</b>			
<b>Company</b>	<b>ID #</b>	<b>Group #</b>	<b>Policy holder name</b>
<p><b>INSURANCE/BILLING:</b> Insurance is filed by this office as a courtesy to the patient. I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. It is the parent's responsibility to be aware of benefits that their insurance provides for well child care and sick visits. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.</p>			
<p><b>PATIENT CONSENT FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:</b> I hereby give my consent for Dr. Soos Pediatrics, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Dr. Soos Pediatrics P.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Soos Pediatrics P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Soos Pediatrics. With this consent, Dr. Soos Pediatrics, P.C. may call my home or other alternative number, may e-mail to my home or other location, to assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to clinical care. I hereby grant permission to Dr. Soos Pediatrics, P.C. to release any pertinent information to my insurance company upon request and I also authorize payment directly to Dr. Soos Pediatrics, P.C. A photocopy of this authorization shall be considered as effective and valid as the original.</p>			
<p><b>REVOKE CONSENT:</b> I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Soos Pediatrics, P.C. may decline to provide treatment to my child.</p>			
<p><b>PERMISSION TO TREAT:</b> As a parent, I understand I must give permission for my child to receive medical treatment. If at all possible, I will come with my child for every appointment at Soos Pediatrics, P.C. If my child comes with anyone other than myself, I agree to send with them a written note, with my signature, giving permission for treatment.</p>			
<b>Parent/Guardian Signature</b>	<b>Date</b>	<b>Witness Signature</b>	<b>Date</b>