The After Owls Pediatric Care

Patient Registration Form

Childs Name: (complete the following)			Today's Date:	
First	Middle	Last	Sex	Date of birth
			F M	
Address	City	State/Zip Code	Child's SS #	
Mother's Name:		DOB:	Social Security #:	
**Address if different from above:				
Home and/or Cell Phone:		Employer:	Work Phone #:	
Father's Name:		DOB:	Social Security #:	
**Address if different from above:				
Home Phone:		Employer:	Work Phone #:	
If Divorced or Separated List Custodial Parent:				
Nearest relative not living with you; Provide phone number				
Who may we contact incase of an emergency? Please provide phone #				

MEDICAL INSURANCE INFORMATION: (Present card at Front Desk) List PRIMARY First

Company	ID #	Group #	Policy holder name

INSURANCE/BILLING: I understand that payment of all medical care/treatment is paid at the time of service. The parent and/or legal guardian who signs this form is responsible for all payments.

PATIENT CONSENT FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: I hereby give my consent for The After Owls Pediatric Care to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). The After Owls Pediatric Care 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. The After Owls Pediatric Care 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 The After Owls Pediatric Care.. With this consent, The After Owls Pediatric Care 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 The After Owls Pediatric Care to release any pertinent information to my insurance company upon request. I also authorize payment directly to The After Owls Pediatric Care.

PHOTOCOPY: A photocopy of this authorization shall be considered as effective and valid as the original.

REVOKE CONSENT: 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, The After Owls Pediatric Care may decline to provide treatment to my child.

PERMISSION TO TREAT: 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 visit at The After Owls Pediatric Care. 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.

Parent/Guardian Signature	Date	Witness Signature	Date

Patient History

NAME:			SEX: MALE FEMALE	DOB:
	NO	YES, AS LISTED:	ALLERGIES:	
BIRTH PROBLEMS?				
HOSPITAL STAY?			IMMUNIZATIONS:	UP TO DATE NOT
SURGERIES?			PRIMARY DOCTOR:	
CHRONIC ILLNESS:		ASTHMA	CURRENT MEDICATIONS:	
		MIGRAINE		
		ALLERGIES		
		SEIZURES	SISTERS?	AGES?
		OTHER	BROTHERS?	AGES?
FAMILY ILLNESS:		ASTHMA	DAYCARE?	WHERE?
		MIGRAINE	SCHOOL?	GRADE?
		ALLERGIES	**FILLED OUT BY:**	
		SEIZURES	MOTHER FATHER OTHER:	
		OTHER	**SIGNATURE**	**DATE**