Patient Registration Form

Today's Date _____ /_____ / _____

Patient

Patient's Full Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Patient's Address_____ Patient's Home Tel# _____ -- _____ -- _____

City, State, Zip _____ Referred by: _____

E-Mail Address: _____

Siblings

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Mother

Mother's Full Name _____ Mother's Work Tel # _____ -- _____ -- _____

Mother's Address _____ Mother's Cell Tel # _____ -- _____ -- _____
(if differs from above)

_____ Mother's Date of Birth _____ / _____ / _____

☐ Lives with Patient Mother's Employer / Occupation _____

Father

Father's Full Name _____ Father's Work Tel # _____ -- _____ -- _____

Father's Address _____ Father's Cell Tel # _____ -- _____ -- _____
(if differs from above)

_____ Father's Date of Birth _____ / _____ / _____

☐ Lives with Patient Father's Employer / Occupation _____

Emergency Contact

Contact's Full Name _____ Contact's Relationship to Patient _____

Contact's Tel # (1st) _____ -- _____ -- _____ Contact's Tel # (2nd) _____ -- _____ -- _____

Authorizations and Consents:

☐ (**Please check**) I authorize treatment of the patient named above by VIPediatrics, PC. I authorize the release of medical records necessary to process insurance claims and to other medical providers involved in my child's care. I authorize payment of medical benefits to be made directly to VIPediatrics, PC.

☐ (**Please check**) I have been presented with a copy of the Notice of Privacy Practices for the office of VIPediatrics, PC detailing how my information may be used and disclosed as permitted under federal and state law.

Signature _____ Date _____ /_____ / _____

Name (Print) _____ Relationship to patient: Mother Father Legal Guardian
(Circle One)