southphiladelphia PEDIATRICS
SOUTH PHILADELPHIA • QUEEN VILLAGE • WHITMAN

Patient Registration Form

Patient Information:

Name: _____ Date of birth: _____ Sex: ___ Male ___ Female

Address:

_____
Street Address City State Zip

Primary phone number: (_____)_____ Primary language:_____

Ethnicity: ___ Hispanic ___ Non-Hispanic ___ Unknown

Race: ___ American Indian or Alaska Native ___ Asian ___ Black or African American

___ Native Hawaiian or Other Pacific Islander ___ White ___ Other (please specify): _____

Parent/Guardian Information:

Parent/Guardian 1:

Name: _____ Date of birth: _____

Relation to patient: _____ Lives with patient: ___ Yes ___ No

Address (if different from above):

_____
Street Address City State Zip

Cell phone: (_____)_____ Home phone: (_____)_____

Email: _____

Employer: _____ Occupation: _____

Parent/Guardian 2:

Name: _____ Date of birth: _____

Relation to patient: _____ Lives with patient: ___ Yes ___ No

Address (if different from above):

_____
Street Address City State Zip

Cell phone: (_____)_____ Home phone: (_____)_____

Email: _____

Employer: _____ Occupation: _____

Emergency Contact (other than parent):

Name: _____ Relation to patient: _____

Phone number: (_____)_____

Insurance:

Primary Insurance: _____

Policy Holder's Name: _____Policy Holder's Birthdate: _____

ID #: _____Group #: _____

Secondary Insurance: _____

Policy Holder's Name: _____Policy Holder's Birthdate: _____

ID #: _____Group #: _____

Consent for Treatment in the Absence of a Parent or Guardian:

Please list any other adults who may bring your child to our office and who may authorize treatment.

Name: _____ Relation to child: _____

Name: _____ Relation to child: _____

_____

Name Signature Date

Financial Policy Agreement:

As a courtesy, South Philadelphia Pediatrics will file a claim for services rendered with my insurance carrier. I authorize the release of any medical information necessary to process insurance claims. I authorize South Philadelphia Pediatrics to bill my insurance or third-party payer and receive payment directly from insurance for services rendered. I understand that I remain financially responsible for all charges not covered by my insurance company. I authorize the use of this signature on all insurance claims.

_____

Name of Responsible Party Signature Date

Privacy Practices Acknowledgment:

I have been provided the opportunity to review South Philadelphia Pediatrics's Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.

_____

Name Signature Date

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Child's Medical and Family History:

Child's Name: _____

Biological Mother's Name: _____

Biological Father's Name: _____

	Child	Mom	Dad	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Allergies								
Asthma								
Lung disease								
Heart condition								
High blood pressure								
High cholesterol								
Diabetes								
Thyroid problems								
Obesity								
Cancer								
Anemia								
Bleeding disorder								
Epilepsy or seizure disorder								
Mental retardation								
Developmental disorder								
Neurologic disorder								
ADD/ADHD								
Liver disease								
GI disorder								
Kidney disease								
Bedwetting (after age 10)								
Hearing impairment								
Vision problem/Eye disorder								
Immune system problems								
HIV/AIDS								
Alcohol abuse								
Drug abuse								
Mental illness								
Tuberculosis								
Other medical problems								