

## PATIENT REGISTRATION

All About Children Pediatric Partners, P.C.    \_\_\_ Penn Ave Office    \_\_\_ 5th Street Office

**I. PATIENT INFORMATION:**                      Acct. #: \_\_\_\_\_                      Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_                      Sex: Male / Female

Social Security Number: \_\_\_\_\_                      Birth date: \_\_\_\_\_                      Age: \_\_\_\_\_ yrs                      \_\_\_\_\_ mos

Child lives with: \_\_\_\_\_                      Birth date: \_\_\_\_\_                      Sex: \_\_\_\_\_                      SSN: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail: \_\_\_\_\_                      Home Phone #: \_\_\_\_\_                      Cell Phone #: \_\_\_\_\_

Siblings: \_\_\_\_\_

Mother Name: \_\_\_\_\_                      Home Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_                      SSN: \_\_\_\_\_                      Cell Phone: \_\_\_\_\_

Father Name: \_\_\_\_\_                      Home Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_                      SSN: \_\_\_\_\_                      Cell Phone: \_\_\_\_\_

### II. INSURANCE INFORMATION:

Primary Insurance: Start date: \_\_\_\_\_                      Termination date: \_\_\_\_\_                      Copay: \_\_\_\_\_

Insurance Company: \_\_\_\_\_                      Policy #: \_\_\_\_\_                      Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_                      SSN: \_\_\_\_\_                      Birth date: \_\_\_\_\_

Relationship to patient: (Mother / Father / Patient / Other \_\_\_\_\_)

Employer: \_\_\_\_\_                      Employer phone number: \_\_\_\_\_

Secondary Insurance: Start date: \_\_\_\_\_                      Termination date: \_\_\_\_\_                      Copay: \_\_\_\_\_

Insurance Company: \_\_\_\_\_                      Policy #: \_\_\_\_\_                      Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_                      SSN: \_\_\_\_\_                      Birth date: \_\_\_\_\_

Relationship to patient: (Mother / Father / Patient / Other \_\_\_\_\_)

Employer: \_\_\_\_\_                      Employer phone number: \_\_\_\_\_

ACCESS (PA Medicaid) Number: \_\_\_\_\_ - \_\_\_\_\_

### III. MEDICAL INFORMATION ABOUT PATIENT: Allergies: \_\_\_\_\_

Has s/he ever had Chickenpox disease? (Circle): Yes / No                      Birthplace (State or Country): \_\_\_\_\_

**Race** (Please circle ALL that apply): Aleut, Arabian, Asian Indian, Black, Cambodian, Caucasian (White), Chinese, Eskimo, Guamanian, Hawaiian, Indian, Indonesian, Japanese, Korean, Laotian, Filipino, Samoan, Thailander, Vietnamese, Other ( please specify ) \_\_\_\_\_

**Hispanic:** (Please circle origin also): Central American (Costa Rica, Ecuador, El Salvador, French Guyana, Guatemala, Guyana, Honduras, Nicaragua, Panama, Suriname, Trinidad), Cuban, Mexican, Puerto Rican, South American (Argentina, Belize, Bolivia, Brazil, Chile, Columbia, Paraguay, Peru, Uruguay, Venezuela), Other \_\_\_\_\_

**Language:** English, Spanish, Arabic, Cambodian, Chinese, French, German, Greek, Pashto, Polish, Romanian, Russian, Turkish, Vietnamese, Other (Please specify): \_\_\_\_\_

### IV. AUTHORIZATION:

- I authorize any treatment needed for the proper care of my child by All About Children Pediatric Partners, PC.
- I authorize payment by my insurance company directly to AACPP of any medical/surgical benefits for the services rendered.
- I understand that I am financially responsible to AACPP for all payments due which are not covered by the applicable insurance plan(s).
- I authorize the release of any information acquired in the course of my examination or treatment to my insurance company to process my claims and/or to a legitimate medical professional if such referral is necessary.

Signature: \_\_\_\_\_                      Date: \_\_\_\_\_