PATIENT REGISTRATION

Rev. 0407/2017 cejk

ACCOUNT #:_____ DATE COMPLETED:_____

[1a] Patient Name:	[2a] M / F	[3a] Birthdate:
[4a] SSN:	[5a] Current School/Grade/Child Care:	[6a] **Race** (Please circle all that apply): White (Caucasian), Black (African), Asian, Middle Eastern, Native American, Polynesian, Other____; [7a] **Latino**: Central American, Cuban, Mexican, Puerto Rican, South American
[8a] **ALLERGIES:**		

PARENT INFORMATION:

[1] **Mother/Guardian Name:**		[2] Birthdate:
[3] Address:		
[4] Home Phone:	[5] Cell Phone:	
[7] SSN:	[8] Email:	
[9] **Father/Guardian Name:**		[10] Birthdate:
[11] Address:		
[12] Home Phone:	[13] Cell Phone:	[14] Work Phone:
[15] SSN:	[16] Email:	

[17] **INSURANCE INFORMATION - Please provide a copy of ALL current health insurance cards or information at every visit**

Social History:

[18] *Who lives in your home?*

[19] *Is this child adopted / in kinship care / in foster care now? Yes / No Have they ever been? Yes / No*

[20] *Family changes in the past 3 years? No / Yes, Please describe:*

[21] **Emergency Contact Name:**	Cell Phone:
Address:	Email:

[22] **Dentist Name:** **Phone:** **Last Appt:**

[23] **These people have my permission to bring my child to AACPP for appointments, schedule appointments, and have access to my child's insurance information. *If this box is checked & initialed, they may also access my child's protected health information , access to the patient portal, and telephone communications from AACPP. (Please provide specific information or legal documentation if needed)**

Name	*Phone #*	*Relationship*	☐ *Access to protected medical information is ok** _____ *Initials*
Name	*Phone #*	*Relationship*	☐ *Access to protected medical information is ok** _____ *Initials*
Name	*Phone #*	*Relationship*	☐ *Access to protected medical information is ok** _____ *Initials*

- *I authorize treatment needed for the proper care of my child by the staff at AACPP, PC to be given with my verbal consent.*
- *I authorize payment by my insurance company directly to AACPP of the medical/surgical benefits, if any, for the services rendered*
- *I understand that I am financially responsible to AACPP for all payments due which are not covered by my insurance plan*
- *I authorize the release of medical information to my health insurance to process claims and to medical professionals for consults.*

[24] *Signature:* Printed Name: Date:

Please bring your child's insurance card, immunization records, and all their medicines to every visit at AACPP.

(Please use the back of this page to provide additional information)