PATIENT REGISTRATION

Rev. 2/12/2020 BS

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____;* **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 AAC 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 AAC. (Please provide specific information or legal documentation if needed)**

☐ *Access to protected medical information is ok**

Name *Phone #* *Relationship* *Initials_____*

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Name *Phone #* *Relationship* *Initials_____*

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Name *Phone #* *Relationship* *Initials_____*

- *I authorize treatment needed for the proper care of my child by the staff at PSHMG-AAC to be given with my verbal consent.*
- *I authorize payment by my insurance company directly to PSHMG-AAC of the medical/surgical benefits, if any, for the services rendered*
- *I understand that I am financially responsible to PSHMG-AAC 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 AAC. (Please use the back of this page to provide additional information)