PREMIER PEDIATRICS, LLC
PATIENT REGISTRATION

Patient Information

Patient's Legal Name: _____ Date of Birth:_____ Sex: ☐ M ☐ F
First Middle Last

Address:_____ Apt._____ Phone :(_____)_____

City:_____ State:_____ Zip Code:_____ SS#_____

Preferred Pharmacy Name/Phone: _____

Race: ☐ Caucasian (White) ☐ African American ☐ Other: _____ ☐ Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____ ☐ Refused to Report

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Child is living with: (check one): ☐ Both Parents ☐ Father ☐ Mother ☐ Parent & Step Parent ☐ Other: _____

Are Parents: (check one): ☐ Married ☐ Single ☐ Never Married ☐ Divorced ☐ Separated ☐ Widowed

Are there any other significant adults involved? If so, who are they?_____

Family Information

Father	**Mother**
Name:_____	Name:_____
SS#_____ DOB_____	SS#_____ DOB_____
Home Phone :(_____)_____	Home Phone :(_____)_____
Work Phone :(_____)_____	Work Phone :(_____)_____
Cell Phone :(_____)_____	Cell Phone :(_____)_____
Email:_____	Email:_____

Emergency Contact Information (A local person other than Parents or Guardians)

Name:_____ Relationship to Patient:_____

Home Phone :(_____)_____ Work Phone :(_____)_____ Cell :(_____)_____

We appreciate referrals. Whom may we thank for referring your family to our office?_____

IMPORTANT! Please read and sign the other side of this form.

CONSENT FOR EXAMINATION, MEDICALTREATMENT AND CONDITIONS OF EXAMINATION IN OFFICE OR VIA TELEMEDICINE

Consent is hereby given to perform any and all examinations (including genital exam), tests, procedures and treatments necessary and or advisable; and in case of an emergency, without the presence of parents or responsible adults, I hereby authorize examination and treatment of the above named patient by the physician, nurse practitioners, physician assistants or designees deemed necessary by the physician. I also authorize telemedicine visits and I am aware of limitations of telemedicine including but not limited to, interruptions, unauthorized access and technical difficulties, and I know I can disconnect the call at anytime. I authorize to view and download external medication history of the patient. I realize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations in this pediatric practice. If I cannot bring my child, the persons listed below will have the authority to bring in and authorize treatment:

Name:	Relationship to patient:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Any person, not listed above must have a dated and signed letter of consent from myself, or treatment could be refused or delayed. I understand that in unusual circumstances, efforts will be made to contact me prior to rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated that such consent for treatment of a minor is cancelled. I have read all the information on this sheet and have completed all the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Premier Pediatrics of any changes to this information in the form of a signed and dated letter.

AUTHORIZATION TO FILE INSURANCE CLAIMS, TO RELEASE MEDICAL INFORMATION, AND ASSIGNMENTOF BENEFITS

- I authorize Premier Pediatrics to file insurance claims for services and supplies rendered to and for my child or myself.
- I authorize Premier Pediatrics to release information, including my child's or my medical and billing information, to referring or consulting doctors and to my insurance company. The transmission of all information may be done electronically, including the internet.
- I authorize that payment of all third party benefits otherwise payable to me be made directly to Premier Pediatrics.
- I assign all payments for medical services and supplies provided to my dependent child or myself to Premier Pediatrics.
- I understand that I am financially responsible to Premier Pediatrics for the above named patient (s). If my insurance company fails to fully compensate Premier Pediatrics any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third party payer within 30 days after notification from Premier Pediatrics, and or a billing company acting on its behalf.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES, AND GUARANTEE OF PAYMENT

- I understand that Premier Pediatrics cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided.
- I acknowledge that the above information is correct and that I am responsible for the balance on my child's or my account for any services not covered or not paid by my insurance plan.

At Premier Pediatrics we appreciate and respect our staff. It is our belief our staff should have a work environment free from verbal and physical abuse. We expect each of you to treat each one of our staff members, as you would like to be treated. Outbursts against our staff, physicians, and covering physician's will not be tolerated and will result in your immediate discharge from the practice.

I understand that I have the right to review the "notice of privacy practices" prior to signing this document. This notice is posted in the lobby and made available at all times. This notice of privacy practices describes my child's or my rights and Premier Pediatrics' duties with respect to my child or my protected health information. By signing below, I certify my agreement and acceptance of the above.

_____		_____
Patient Name		**DOB**
_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**

Revised: 06/07/2022