BRENTWOOD PEDIATRICS PATIENT REGISTRATION

Patient Name: _____

Gender (circle one) Male / Female Date of Birth_____SSN#:_____

Address_____

City:_____State: _____Zip:_____

Primary Phone:_____Secondary Number:_____

Parent/Guardian (*PRIMARY*): _____ Occupation: _____

Parent Social Security _____Date of Birth:_____

Parent/Guardian (*SECONDARY*):_____ Occupation: _____

Parent Social Security _____Date of Birth:_____

Email address so that we may set up your patient portal: _____

Please list any Siblings_____

Insurance Information ***PLEASE PRESENT COPY OF YOUR CARD AT EACH APPOINTMENT***

Primary Insurance Carrier: _____ Employee: _____

Secondary Insurance Carrier: _____ Employee: _____

******CO-PAYS, DEDUCTIBLES AND NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE******

Pharmacy Name:_____**Phone Number:**_____

Address:_____

Emergency Contact_____ **Relationship to patient**_____

Address _____**Phone:**_____

****Please circle****

Race: Asian Black/African American Hispanic Other Pacific Islander White Other Refused to report

Ethinicity: Hispanic Non Hispanic Refused to report

Language: English Other Refused to report

Please acknowledge you have received Brentwood Pediatrics HIPAA policy via □ hard copy □ email _____ please initial

This signature authorizes Brentwood Pediatrics, PLLC permission to file appropriate insurance claims, and hold you financially responsible for any services preformed for your child's care. Should your account be referred to an outside collections agency, you will be responsible for any collections fees.

Signature:_____**Date:**_____

The undersigned parent or legal guardian of _____ (child's name) authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, surgical services and vaccines when I am not immediately available in person, or by a telephone call to _____ (parent's phone #). It is understood that this consent is given in advance of any specific diagnosis or treatment and allows that physician/provider to diagnose and treat the child even when the parent or guardian is not present (please include any person who you may allow to bring your child in).

Name: _____ Relationship to child: _____ Phone: _____

Name: _____ Relationship to child: _____ Phone: _____

Name: _____ Relationship to child: _____ Phone: _____

Name:_____Relationship to child:_____Phone:_____

Name of Parent/Legal Guardian:_____Relationship to child: _____

Signature: _____ Date: _____