PATIENT REGISTRATION FORM

ORCHARD PEDIATRICS **2018** **FAMILY NAME** _____

PARENT 1 BIRTHDATE	PARENT 2 BIRTHDATE
WHICH PARENT(S) HAVE LEGAL AUTHORITY TO MAKE MEDICAL DECISIONS? _____	
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
HOME PHONE ( ) CELL PHONE ( )	HOME PHONE ( ) CELL PHONE ( )
WORK PHONE ( ) PREFERRED METHOD OF CONTACT:	WORK PHONE ( ) PREFERRED METHOD OF CONTACT:
EMAIL ADDRESS	EMAIL ADDRESS
SOCIAL SECURITY #	SOCIAL SECURITY #
EMPLOYER	EMPLOYER
INSURANCE COMPANY POLICY#	INSURANCE COMPANY POLICY #

I DO / DO NOT (PLEASE CIRCLE ONE) GIVE PERMISSION TO LEAVE BASIC INFORMATION ON MY PERSONAL VOICE MAIL.

LIST THE **LEGAL NAME OF ALL CHILDREN** THAT ARE PATIENTS IN THIS OFFICE (INCLUDE LAST NAME IF DIFFERENT FROM ABOVE)

NAME	BIRTHDATE	MALE / FEMALE	
_____	_____	_____	ACCT # _____
_____	_____	_____	ACCT # _____
_____	_____	_____	ACCT # _____
_____	_____	_____	ACCT # _____

HAVE THERE BEEN ANY CHANGES IN YOUR CHILDREN'S PERSONAL OR FAMILY HEALTH HISTORY O YES O NO IF YES, PLEASE REQUEST A HEALTH HISTORY FORM

WHICH INSURANCE POLICY ARE THE CHILDREN ON? _____ IF BOTH, WHICH IS THE PRIMARY POLICY? _____

IF MOTHER AND FATHER HAVE DIFFERENT ADDRESSES, WHERE DO THE CHILDREN LIVE? _____

WHO SHOULD RECEIVE BILLING STATEMENTS? _____

EMERGENCY CONTACT PERSON (SOMEONE NOT LIVING IN YOUR HOME) NAME: _____ TELEPHONE: _____

PLEASE READ AND SIGN

I, _____ THE MOTHER / FATHER OF (LIST ALL CHILDREN) _____

1. I GIVE ORCHARD PEDIATRICS, P.C. PERMISSION TO TREAT MY CHILDREN SHOULD ANY OR ALL OF THEM PRESENT TO YOUR OFFICE WHEN NOT ACCOMPANIED BY A PARENT. THIS CONSENT SHALL BE VOID UPON WRITTEN REQUEST.
2. PERMISSION IS GRANTED TO ORCHARD PEDIATRICS, P.C., TO RELEASE REQUESTED INFORMATION TO MY INSURANCE COMPANY FOR BILLING PURPOSES OR PATIENT-CENTERED MEDICAL HOME (PCMH) WELLCENTIVE PATIENT REGISTRY.
3. I AUTHORIZE PAYMENT FOR MEDICAL SERVICES BY MY INSURANCE COMPANY TO ORCHARD PEDIATRICS, P.C.
4. IF MY CHILD'S INSURANCE CARRIER DENIES PAYMENT OF SERVICES, I UNDERSTAND THAT I AM REPSONSIBLE FOR PAYMENT OF ALL CHARGES.
5. PERMISSION IS GRANTED TO ORCHARD PEDIATRICS, PC TO IMPORT MY CHILD'S MEDICAL INFORMATION ELECTRONICALLY.

SIGNATURE _____ DATE_____ OFFICE WITNESS _____DATE_____

rev 2/21/2018