East West Pediatrics – Registration

Patient Name:_____Date of Birth: _____Sex:_____

Home Address: _____

Email Address:_____

Phone (H): _____Work:_____Cell:_____

Social Security Number:_____

Mother's Name: _____ Date of Birth:_____SS#:_____

Mother's Address:_____

Email Address:_____

Mother's Employer:_____Phone:_____

Employer's Address:_____

Father's Name: _____ Date of Birth:_____SS#:_____

Father's Address:_____

Email Address:_____

Father's Employer:_____Phone:_____

Employer's Address:_____

Primary Health Insurance Co:_____Phone:_____

Policy ID#:_____Group #:_____

Policy Holder:_____Relationship to Patient:_____

Secondary Health Insurance Co:_____Phone:_____

Policy ID#:_____Group #:_____

Policy Holder:_____Relationship to Patient:_____

In Case of Emergency Contact (other than parent):_____

Relationship to Parent:_____Phone:_____

Authorization to Seek Medical Treatment

The following individuals are authorized to seek medical treatment for my children in my absence:

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient:_____

Signature of Parent:_____Date:_____

Authorization to Leave Phone Messages:

I hereby authorize East West Pediatrics, including staff and physicians to leave messages on my answering machine at my ☐ Work ☐Home ☐Cell Phone (check applicable boxes) that could contain private medical information including, but not limited to, reminders of appointments, answers to messages, and medical test results of a personal nature.

Signature of Parent/Patient (if over 18 years):_____Date:_____

Insurance Authorization and Release: I hereby authorize East West Pediatrics, LLC to release information from my records to persons who have need for this information such as insurance companies, doctors and other agencies or professionals involved in my care. East West Pediatrics personnel are authorized to determine which persons or agencies are in need of such information. I hereby authorize Medicaid and/or any insurance company to pay East West Pediatrics directly for services provided. I agree to accept financial responsibility for services provided at East West Pediatrics for the patient.

Signature:_____Date:_____

Notice of Privacy Practices Receipt: I hereby acknowledge that I have received a copy of the Notice of Use of Private Health Information.

Signature:_____Date:_____

How did you hear about our practice?

☐Referred by a friend ☐Referred by Insurance Co

☐Referred by another doctor ☐Internet Search

☐Other_____