

Patient Registration

Patient Registration

Patient Sex M F DOB..... SS#

Mother DOB SS#

Address Home # Cell #

City/State/Zip..... Email

Employer Work #.....

Father DOB SS#

Address Home # Cell #

City/State/Zip..... Email

Employer Work #.....

Sibling Sex M F DOB..... SS#

Sibling Sex M F DOB..... SS#

Sibling Sex M F DOB..... SS#

Children live with: M F Guardian Grandparents Other

Emergency Contact..... Relation..... Phone #

Party responsible for Payment of Medical Services M F Guardian Grandparents Other

How did you hear about our practice?

Insurance Information

Primary Claim Address.....

Policy #..... Group#..... Co-pay

Secondary Claim Address.....

Policy #..... Group#..... Co-pay

Name of Insured..... DOB Relation.....

Primary Care Physician..... Phone #..... City.....

Authorization of Treatment and Assignment of Benefits

I authorize Dr. Karen Harum to treat my child. I further authorize release of medical information necessary for the completion of insurance forms. I authorize payment directly to Clinic for Special Children for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following..... I understand that if my child's physician, or any person employed by or under the direction or control of my child's physician, is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines of the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's bodily fluids.

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Parent/Guardian Signature

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Relationship

.....
Date

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Witness Signature

.....
Date