Morningside Pediatrics Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Not Hispanic / Unknown
Circle one

Race: Am. Indian or Alaskan/Asian / Black / Hawaiian / White /Unknown
Circle all that apply

Details: _____

Details: _____

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Primary Phone: (_____) _____ - _____

Who lives at this household? _____
(Please note, this information is being requested to improve intake of your child's Social History.)

Contact 1: *Name*: _____

Relation to Patient: _____ *Biological Relation to Patient:* _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: ____ _____ *Work Email:* _____

How would you ideally prefer to be contacted regarding (circle one):

Recall Notices: Cell Phone (text) / Primary Phone (call) / Home Email

General Practice Notices: Cell Phone (text) / Primary Phone (call) / Home Email

Patient Portal Notifications: Cell Phone (text) / Primary Phone (call) / Home Email

Appointment Reminders: Cell Phone (text) / Primary Phone (call) / Home Email

Contact 2: *Name*: _____

Relation to Patient: _____ *Biological Relation to Patient:* _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: ____ _____ *Work Email:* _____

If this contact will need to be notified in addition to Contact 1 for Appointment Reminders, Recall Notices, General Practice Notices and Patient Portal Notifications list their preferences here:

_____

_____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____ *ID#* _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____ *ID#* _____

If parents are divorced or separated please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents: Name & Relationship

1: _____ Relationship _____ *Phone*: (___) _____ - _____

2: _____ Relationship _____ *Phone*: (___) _____ - _____

3: _____ Relationship _____ *Phone*: (___) _____ - _____

I authorize the providers of Morningside Pediatrics to provide medical treatment for my child on an ongoing basis until this consent is revoked. I also allow the individuals listed on this form to provide consent for my child. I consent in the event that my child, once over 14 years of age, arrives unaccompanied by an adult.

I authorize the release of any medical information necessary to process this claim, and future claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Morningside Pediatrics to apply for benefits on my behalf for covered services rendered by the, or by their order. I request that payment from my insurance company be made directly to Morningside Pediatrics. I certify that the information I have reported with my insurance coverage is correct. In the event that a service or product is not coered by my insurance, I understand that I will be personally responsible for payment. This authorization may be revoked by either me or the insurance company at any time, in writing. I understand that my records may be copied and transferred upon written request, for a fee. I understand that there is a $25 fee for a missed appointment or appointments canceled with less than 24 hours notice.

SIGNATURE:_____DATE:_____

I, _____, have received a copy of Morningside Pediatrics; "Notice of Privacy Practices".

SIGNATURE:_____DATE:_____