Springdale-Mason
PEDIATRIC ASSOCIATES, INC.

Patient Registration Form

Patient Information:

Children's Names	Birthdate	Sex	If patient is 18 or over we need his/her phone number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Preferred Pharmacy: _____ Location: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Father's Information

Name: _____ Birthdate: _____

Address: _____
(Street) (City, State, Zip)

Telephone: Home: _____ Cell: _____ Work: _____

Email Address: _____ Lives with patient? Yes / No

Mother's Information

Name: _____ Birthdate: _____

Address: _____
(Street) (City, State, Zip)

Telephone: Home: _____ Cell: _____ Work: _____

Email Address: _____ Lives with patient? Yes / No

Additional Contact Questions

Who should receive billing statements? _____

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

Male Step-Parent (if applicable) _____ Phone Number:_____

Legal Male Guardian (if applicable) _____ Phone Number: _____

Relationship to Patient: _____

Female Step-Parent (if applicable) _____ Phone Number: _____

Legal Female Guardian (if applicable) _____ Phone Number: _____

Relationship to Patient: _____

Insurance Information

Primary Insurance Coverage: _____
(Company name) (Claims mailing address)

Subscriber Name: _____ Birthdate:_____

SS#: _____-_____-_____ Policy #: _____ Group #: _____

Employer: _____ Effective date of coverage: _____

Secondary Insurance Coverage: _____
(Company name) (Claims mailing address)

Subscriber Name: _____ Birthdate:_____

SS#: _____-_____-_____ Policy #: _____ Group #: _____

Employer: _____ Effective date of coverage: _____

I hereby authorize Springdale-Mason Pediatrics (SMP) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by SMP healthcare providers and hereby direct my insurance carrier or its intermediaries to issue payment directly to Springdale-Mason Pediatrics on behalf of such rendered services.

I understand that I am financially responsible to the office for any balance not covered by my insurance carrier.

Signature: _____ Date: _____

In the event that the parent(s) or legal guardian(s) are unable to accompany the child during an office visit, I hereby authorize the physicians of Springdale-Mason Pediatrics to evaluate and treat any and all conditions that require attention.

Signature: _____ Date: _____

I give Springdale-Mason Pediatrics permission to leave information that includes patient name, and limited medical information on my voice mail or answering machine.

Signature: _____ Date: _____

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice. I am also aware that I may I may review the Notice of Privacy Practices at any time.

Signature: _____ Date: _____

THE QUESTIONS ON THIS PAGE ARE ALL FOR FUTURE USE ONCE OUR TRANSFER OVER TO ELECTRONIC MEDICAL RECORDS IS COMPLETED. FILLING OUT THIS PAGE IS OPTIONAL AS OF NOW, EVENUALLY WE WILL NEED ALL OF THE INFORMATION.

Child's Name:____ Primary Language:___________________________

Ethnicity: Unknown / Hispanic or Latino / Non-Hispanic or Non-Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African American / Hawaiian / White / Decline to specify

Child's Name:____ Primary Language:___________________________

Ethnicity: Unknown / Hispanic or Latino / Non-Hispanic or Non-Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African American / Hawaiian / White / Decline to specify

Child's Name:____ Primary Language:___________________________

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Race: American Indian or Alaskan Native / Asian / Black or African American / Hawaiian / White / Decline to specify

Child's Name:____ Primary Language:___________________________

Ethnicity: Unknown / Hispanic or Latino / Non-Hispanic or Non-Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African American / Hawaiian / White / Decline to specify

How would you ideally prefer to be contacted regarding (circle one including which parent if applicable):

Medical Issues: Home Phone / Work Phone (Mom or Dad) / Cell Phone (Mom or Dad) / Email Address (Mom or Dad)

Appointment Reminders: Home Phone / Cell Phone (Mom or Dad) / Email Address (Mom or Dad)

Recall Notices: Home Address / Home Phone / Work Phone (Mom or Dad) / Cell Phone (Mom or Dad) / Email (Mom or Dad)

Billing Statements: Home Address / Email (Mom or Dad)

General Practice Notices: Home Address / Home Phone / Cell Phone (Mom or Dad) / Email Address (Mom or Dad)

Patient Portal Notifications: Cell Phone (Mom or Dad) / Email Address (Mom or Dad)