Your insurance card & proof of identity such as a driver's license are required in order to bill your insurance for services.

If you do not have your insurance card at your visit, please be prepared to pay for services rendered at the time of service.

<u>PATIENT INFORMATION</u>		Today's Date:			
Patients first name	Middle	Last Na	ame	Nickname	
Date of Birth Sex		Current/ Previous Physician's Name and office number			
Patient Address (Street, Route	e, Apt., Etc.)	City	State	Zip Code	
Mailing Address (if different)		City	State	Zip Code	
INSURANCE INFORMA	<u>TION</u>				
Primary Insurance Company Name		Policy Number	Gro	Group/Plan Number	
Cardholders Name		Date of Birth	Effectiv	ve Date of Coverage	
	y Name	Policy Number	Gro	up/Plan Number	
financially responsible fo	r all charges whether o s as well as to release i	e payable to me for services r not paid by insurance. I her information necessary for the	eby authorize the us		
Mother's Name		Father's Name			
Spouse's Name		Spouse's Name	,		
Address, City, St., Zip		Address, City, S	Address, City, St., Zip		
Home Phone Number ( )		Home Phone No	Home Phone Number ( )		
Cell Phone Number ( )		Cell Phone Nu	Cell Phone Number ( )		
Employer's Name		Employer's Nan	Employer's Name		
Work Phone Number ( )		Work Phone Number ( )			

treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bour by our agreement.  By signing the patient registration form, you consent to our use and disclosure of protected health information about you child for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.  Once we have received your consent, all subsequent treating or consulting physicians, other health care professionals, laboratories, health care facilities, and health insurance companies, may receive copies of medical records without specific authorization, with the exception of records of genetic testing, mental health, alcoholism, drug abuse and HIV/AIDS treatment.  I request a complete copy of Dover Pediatrics, PLLC's Summary Notice of Health Information Practices (HIPAA)  Parent/Guardian Signature  Date  PRIVACY NOTICE  Lauthorize Dover Pediatrics to SHARE PERTINENT MEDICAL INFORMATION only as necessary with other healthcare providers to provide coordination of, or a continuation of medical care. I understand this may incluses ensitive information such as, but not limited to: Mental Health, HIV/STD evaluations and/or treatment, pregnan and alcohol or substance abuse.  Lauthorize Dover Pediatrics to RECEIVE PERTINENT MEDICAL INFORMATION from any provider they have referred my child to. I may restrict, in writing, the release of any confidential information, previously authorized except as required by law and to the extent that action has already been taken on my behalf and that does not compromise accepted standards of medical care. I understand and accept the potential risk/consequence of sending insurance or medical information by FAX.  Please check off applicable boxes:  Today's Date:  LEAVING A MESSAGE AT HOME OR ANSWERING MACHINE  LEAVING A MESSAGE AT HOME OR ANSWERING MACHINE	Patier	nt's First Name	Last Name	Date of Birth
about your child. You have the right to review our notice before signing this consent. As provided in our notice, the terr of our notice may change. If we change our notice, you may obtain a revised copy by asking for an updated copy or contacting the HIPAA compliance officer.  You have the right to request that we restrict how protected health information about your child is used or disclosed for reatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bour by our agreement.  By signing the patient registration form, you consent to our use and disclosure of protected health information about you child for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.  Once we have received your consent, all subsequent treating or consulting physicians, other health care professionals, aboratories, health care facilities, and health insurance companies, may receive copies of medical records without specific authorization, with the exception of records of genetic testing, mental health, alcoholism, drug abuse and HIV/AIDS treatment.  In I request a complete copy of Bover Pediatrics, PLLC's Summary Notice of Health Information Practices (HIPAA)  Parent/Guardian Signature  Date  PRIVACY NOTICE  Lauthorize Dover Pediatrics to SHARE PERTINENT MEDICAL INFORMATION only as necessary with other healthcare providers to provide coordination of, or a continuation of medical care. I understand this may incluse sensitive information such as, but not limited to: Mental Health, HIV/STD evaluations and/or treatment, pregnan and alcohol or substance abuse.  Lauthorize Dover Pediatrics to RECEIVE PERTINENT MEDICAL INFORMATION from any provider they have referred my child to. I may restrict, in writing, the release of any confidential information, previously authorized companies accepted standards of medical care. I understand and accept the potential ris	Pati	ent Consent F	<u>orm</u>	
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child for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.  Once we have received your consent, all subsequent treating or consulting physicians, other health care professionals, aboratories, health care facilities, and health insurance companies, may receive copies of medical records without specific authorization, with the exception of records of genetic testing, mental health, alcoholism, drug abuse and HIV/AIDS treatment.  I request a complete copy of Dover Pediatrics, PLLC's Summary Notice of Health Information Practices (HIPAA)  Parent/Guardian Signature  Date  PRIVACY NOTICE  I authorize Dover Pediatrics to SHARE PERTINENT MEDICAL INFORMATION only as necessary with other healthcare providers to provide coordination of, or a continuation of medical care. I understand this may incluses essitive information such as, but not limited to: Mental Health, HIV/STD evaluations and/or treatment, pregnan and alcohol or substance abuse.  I authorize Dover Pediatrics to RECEIVE PERTINENT MEDICAL INFORMATION from any provider they have referred my child to. I may restrict, in writing, the release of any confidential information, previously authorized except as required by law and to the extent that action has already been taken on my behalf and that does not compromise accepted standards of medical care. I understand and accept the potential risk/consequence of sending insurance or medical information by FAX.  Please check off applicable boxes:  Today's Date:  LEAVING A MESSAGE AT HOME OR ANSWERING MACHINE  LEAVING A MESSAGE AT HOME OR ANSWERING MACHINE  LEAVING A MESSAGE ON CELL PHONE  LEAVING A MESSAGE WITH:	treatm	ent, payment or heal	- ·	•
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□ Scanned in EHR