DOVER PEDIATRICS, PLLC **PEDIATRIC REGISTRATION FORM**

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.

PATIENT INFORMATION

***Today's* Date:** _____

Patients first name **Middle** **Last Name** **Nickname**

Date of Birth **Sex** **Current/ Previous Physician's Name and office number**

Patient Address (Street, Route, Apt., Etc.) **City** **State** **Zip Code**

Mailing Address (if different) **City** **State** **Zip Code**

INSURANCE INFORMATION

Primary Insurance Company Name **Policy Number** **Group/Plan Number**

Cardholders Name **Date of Birth** **Effective Date of Coverage**

Secondary Insurance Company Name **Policy Number** **Group/Plan Number**

Cardholders Name **Date of Birth** **Effective Date of Coverage**

- *I certify that I or my dependent above have insurance coverage as indicated above and assign directly to Dover Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims.*

PARENT/GUARDIAN INFORMATION

Mother's Name

Spouse's Name

Address, City, St., Zip

Home Phone Number ( )

Cell Phone Number ( )

Employer's Name

Work Phone Number ( )

Father's Name

Spouse's Name

Address, City, St., Zip

Home Phone Number ( )

Cell Phone Number ( )

Employer's Name

Work Phone Number ( )

_____ _____ _____

Patient's First Name **Last Name** **Date of Birth**

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. You have the right to review our notice before signing this consent. As provided in our notice, the terms 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 treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing the patient registration form, you consent to our use and disclosure of protected health information about your 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

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 include sensitive information such as, but not limited to: Mental Health, HIV/STD evaluations and/or treatment, pregnancy 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:*** _____

YOU HAVE MY PERMISSION TO CONFIRM MY APPOINTMENTS BY:

□ **LEAVING A MESSAGE AT HOME OR ANSWERING MACHINE**

□ **LEAVING A MESSAGE AT WORK**

□ **LEAVING A MESSAGE ON CELL PHONE**

□ **LEAVING A MESSAGE WITH:**

Name: _____

Relationship: _____ **Phone:** _____

We may discuss your child's medical information/condition with: ***(List each Name/Relationship)***

_____

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