Patient/Minor Registration

The Center For Pediatric and Adolescent, Medicine, L.L.C.

Date _____

Office Use Only
_____ Initials

(PLEASE PRINT)
COMPLETE FULLY

PLEASE CHOOSE A PRIMARY CARE PHYSICIAN

☐ **HENRY M. PELTIER, M.D.** ☐ **KENNETH J. CRUSE, M.D.**

PATIENT INFORMATION

Patient Name: _____ (Last Name) _____ (First Name) _____ (Middle Name) D.O.B. ___/___/___ Age: _____

Sex: ☐ M ☐ F Patient SS#: ___ ___ ___ / ___ ___ / ___ ___ ___ ___ Home Ph: _____

Mother's Cell: _____ Father's Cell: _____ Other: _____

Patient Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Patient Mailing Address: (If different from home) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Personal Financially Responsible: _____ Relationship: _____

Home Ph: _____ Cell Ph: _____

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

Email Address: _____ (provide) ☐ To receive notices via e-mail ☐ Patient Portal Access ☐ Text/ Voice

Do you have any restrictions on how we may contact you: _____

Race (please select one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Patient Preferred Language (please select one): ☐ English ☐ Sign Language ☐ Other _____

PARENT/GUARDIAN INFORMATION

Father's/Guardian's Name: _____

Preferred Language (please select one):

☐ English ☐ Sign Language ☐ Other _____

Marital Status: M / S / D / W (Circle One)

Address (If different from patient's):

_____

Home Ph: _____ (If different from above) Work Ph: _____ (If different from above)

Employer: _____

Emplt. Sts. F / P / U _____ D.L. #: _____

Soc. Sec. #: __ __ __ / __ __ / __ __ __ __ D.O.B. ___/___/___

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name: _____

Is Coverage for Patient Primary or Secondary? (Circle One)

Mother's/Guardian's Name: _____

Preferred Language (please select one):

☐ English ☐ Sign Language ☐ Other _____

Marital Status: M / S / D / W (Circle One)

Address (If different from patient's):

_____

Home Ph: _____ (If different from above) Work Ph: _____ (If different from above)

Employer: _____

Emplt. Sts. F / P / U _____ D.L. #: _____

Soc. Sec. #: __ __ __ / __ __ / __ __ __ __ D.O.B. ___/___/___

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name: _____

Is Coverage for Patient Primary or Secondary? (Circle One)

Please provide the receptionist with a copy of your Health Insurance ID Card.

COMMUNICATION CONTACTS

Please list below a person(s) - (other than Parent/Guardian) to whom we can disclose (share) information regarding your child's medical treatment/care, authorize treatment/care, and/or pick up prescriptions **(PHI is to be disclosed to the following listed.)**

☐ **DECLINE ANY CONTACTS OTHER THAN PARENT (S) OR GUARDIAN**

Name: _____ **Phone:** _____ **Name:** _____ **Phone:** _____

Name: _____ **Phone:** _____ **Name:** _____ **Phone:** _____

RELEASE AND AGREEMENT

The information that I have given is correct to the best of by knowledge. I understand that it will be held in strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status. I also consent to the treatment of my minor child.

I certify that my minor/child is covered by the above insurance company(s) listed and assign directly to The Center for Pediatric and Adolescent, Medicine, L.L.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially responsible for all charges whether or not paid by insurance. I understand that a 1.5% monthly (not to exceed 18% annually) interest charge will be applied to any balance owed by me - past 30 days, and that I am responsible for any additional fees which may be incurred to collect this account, including but not limited to attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Completed by: ☐ Parent/Guardian ☐ Patient (18 yrs. or older) ☐ Patient Representative - Relationship: _____
(Attach a copy of the document granting authority.)

Signature: _____ Date: _____

Print Name: _____