Suburban Healthcare Associates

# PEDIATRIC REGISTRATION FORM

| Patient's First Name | Patient's Last Name | DOB | Sex |
|---|---|---|---|
| | | | |

**Race**
☐ White/Caucasian ☐ Black/African American
☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ Other Race ☐ American Indian/Alaskan

**Ethnic Origin**
☐ Hispanic ☐ Non-Hispanic

**Language** _____

**Child Lives With**
☐ **Father**
☐ **Mother**
☐ **Both Parents**
☐ **Guardian***

***Legal documents must be provided**

| **Father's Name:** | **Mother's Name:** |
|---|---|
| **DOB:** **SSN #:** | **DOB:** **SSN #:** |
| Address: | Address: |
| City, State, Zip: | City, State, Zip: |
| Home Phone: Cell: | Home Phone: Cell: |
| Work #: | Work #: |
| **Family Email:** | |

| **Primary Insurance:** | **Secondary Insurance:** |
|---|---|
| Subscriber's Name: | Subscriber's Name: |
| Co-Pay: | Co-Pay: |
| Group #:<br>ID #: | Group #:<br>ID #: |

| **Preferred Pharmacy:** | **Pharmacy Address/Intersection:** |
|---|---|
| | |

**I have read and agree to all insurance, consent, immunization treatment and payment policies unless otherwise noted. I have read and received information regarding the I-care Registry.**

**1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) We are required by applicable federal and state law to maintain the privacy of your medical information. Our Notice of Privacy Practices document informs you of our legal duties, and your rights concerning your medical information. We must follow the privacy practices described in our notice. You may request a copy of our notice at any time. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Suburban Healthcare. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Suburban Healthcare.**

_____ _____ _____

**Signature (Parent/Guardian)** **Date** **Doctor's Signature**

| **Emergency Contact:** | **Phone:** | **Relationship to Patient:** |
|---|---|---|
| | | |

| **Front Office Use Only:** | **Verified:** | **Scanned:** | **MU Entered:** |
|---|---|---|---|
| **Medics:** | | | |