Watoto Pediatric & Adolescent Specialty, LLC

PATIENT REGISTRATION

Last Name, First Name Nickname DOB Sex Race/ Ethnicity

[For EHR Meaningful Use]

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_____

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_____

Mother's Name _____

Date of Birth ____/____/____ SS# _____-_____-_____ City/Zip Code

Home Address _____

Home Phone (____)_____-_____ Cell Phone (____)_____-_____ Email _____

Occupation _____ Place of Employment _____

Work Phone (____)_____-_____ Ext _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Father's Name _____

Date of Birth ____/____/____ SS# _____-_____-_____ City/Zip Code

Home Address _____

Home Phone (____)_____-_____ Cell Phone (____)_____-_____ Email _____

Occupation _____ Place of Employment _____

Work Phone (____)_____-_____ Ext _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Emergency Contact: Name: _____ Relation _____ Phone _____

Legal Guardian: Name: _____ Relation _____ Phone _____

I authorize the individuals listed below to be involved in my children's medical treatment, including bringing them in for visits:

_____ _____

Name and Relationship Name and Relationship

_____

Parent or Legal Guardian Signature

Insurance Information (Please give your insurance card(s) and Photo ID to the receptionist):

Primary Insurance Company's Name _____

Policy Holder's Name _____

Member ID# _____ Group # _____

Secondary Insurance Company's Name_____

Policy Holder's Name _____

Member ID# _____ Group # _____

Insurance Assignment and Releases

I, the undersigned hereby assign, transfer and set over to Watoto Pediatric & Adolescent Specialty all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for me by Watoto Pediatric & Adolescent Specialty and I direct my insurance company to pay any and all such entitlements directly to Watoto Pediatric & Adolescent Specialty.

_____ _____

Parent or Legal Guardian Responsible for Account Date

I authorize Watoto Pediatric & Adolescent Specialty to render medical care to my child. **I understand that all co-pays and deductibles are to be paid at the time of service**. In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I agree to pay any and all costs of collection including attorney's fees. In the event that my child is hospitalized, I authorize the release of any medical information necessary to process an insurance claim and I authorize payment of medical benefits directly to Watoto Pediatric & Adolescent Specialty. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy. I will assist in the collection of my insurance benefit should there be any delay in payment. I have received the attached "Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law.

I have received the attached "Office Policies and Procedures" and agree to its terms.

_____ _____

Parent or Legal Guardian Signature Date

Whom may we thank for referring you? _____