Patient Registration

Have you been treated before by a doctor from this practice at our previous locations? ☐ Yes ☐ No

PATIENT INFORMATION:

Name: _____ DOB:_____ ☐ Male ☐ Female ☐ Transgender

Race _____ Ethnicity _____ Language_____

Mailing Address: _____City_____ State: _____ Zip:_____

Street Address (if different from above): _____

Phone Numbers: Home_____ Work: _____ Cell: _____

Email Address: _____

Parent / Guardian Name:_____ DOB: _____

Parent / Guardian Name: _____ DOB: _____

PRIMARY INSURANCE

Name:_____

Policy Number _____

Group Number _____

Insured Name: _____ DOB: _____

SECONDARY INSURANCE

Name _____

Policy Number _____

Group Number _____

Insured Name: _____ DOB: _____

EMERGENCY CONTACT:

Name: _____ Relationship to Patient:_____

Address: _____ City_____ State: _____ Zip:_____

Phone Numbers: Home_____ Work: _____ Cell: _____

RESPONSIBLE PARTY *(if different from the patient) person responsible for bills, not necessarily the insurance subscriber:*

Name: _____ DOB:_____ Relationship to Patient: _____

Mailing Address: _____ City_____ State: _____ Zip:_____

Phone Numbers: Home_____ Work: _____ Cell: _____

Email Address: _____

Signature of patient/legally responsible party _____ **Date:** _____

Printed name of legally responsible party_____

Please complete all sections prior to your visit. The signature of the patient, the custodial parent, or the legally responsible party is required.

Name of patient: _____ DOB_____

Payment, Assignment, and Release

I understand that this office may bill my insurance carrier/government program as a courtesy to me but that I am financially responsible for all fees incurred and I agree to pay them in full. I assign all benefits payable to me by my insurance carrier/government program to Aquidneck Pediatrics. I allow a photocopy of my signature to be used to process my insurance/government program claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my health care policy and what I am required to do to secure those benefits.

Signature_____ Date_____

Pharmacy Information:.

Name_____ Location_____ Phone _____

Mail Order Name: _____ Fax # _____

Permission to leave Messages

By Signing Below, I authorize Aquidneck Pediatrics to leave or send non clinical messages in reference to any items that assist in carrying out my healthcare.

Preferred Communication: ☐ Text ☐ Voicemail Preferred Phone: Home ☐ Cell ☐ Work ☐

Signature:_____ Date:_____

RX History Consent

By signing below, I agree to allow Aquidneck Pediatrics to review any prescription history available to my electronic health record.

Signature_____ Date_____

For Minors:

Persons or agencies with a legal right to access this minor's medical record (such as parents, grandparents, DCYF) It is assumed both parents may access the record legally unless documentation to the contrary is provided, such as proof of termination of parental rights.

_____ _____

_____ _____

Disclosure of Protected Health Information of a Minor *(only applicable for minor patient's age 11 through 18th birthday)*

I understand that medical records containing the following information about the care listed below:

- HIV testing and treatment
- Testing and treatment for reportable sexually transmitted diseases;
- Family Planning and abortion services; and
- Alcohol and drug treatment services.

by law, cannot be disclosed by Aquidneck Pediatrics to the parent/guardian of a minor patient unless permission is granted by the minor. On some occasions, Aquidneck Pediatrics may call the minor about the release of his/her information. Minor cell phone number: _____