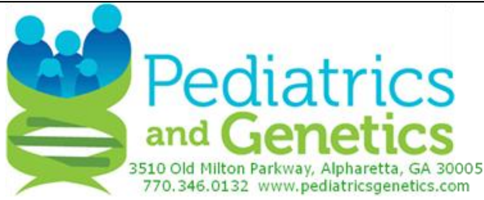

Today's Date ____ / ___ /_______

PATIENT INFORMATION

Patient Name:___________________________________ Date of Birth ____ / ____ / ____ ☐ Male ☐Female

Patient Social Security Number __ __ __ - __ __ - __ __ __ __ (Mandatory for Medicaid Patients)

Present Active Medications 1.___________________ 2.________________________ 3.______________________
☐ None

Medication Allergies 1.___________________ 2.________________________ 3.______________________
☐ None

Other Providers helping Patient 1.__________________ 2.______________________ 3.______________________
(related to chief complaint) __________________ ______________________ ______________________
☐ None

Pharmacy Contact: Name____ Phone ____________Fax ____________

How did you hear about us? ☐ Other Patients ☐ Insurance Co ☐ Internet ☐ Provider Referral
For Provider Referrals, Please Specify ☐ PCP ☐ Specialist
Name ____________________ Address ____

GUARANTOR /CUSTODIAN INFORMATION

Mothers name:__________________________________ DOB:_____________________________________
Fathers name:__________________________________ DOB:____
Address: ____
____

Guarantor __________________________________ Patient Relationship: ______________________________
Social Security Number:__ __ __ - __ __ - __ __ __ __ Email: ____
Phone ☐ Home _________________ ☐ Work ____________________ ☐ Cell ______________________
Emergency Contact: ______________________________ ☐Phone __________________________________

CONSENT FOR DISCLOSURE under HEALTH INSURANCE AND PORTABILITY ACT (HIPAA)

Your signature below represents consent for Pediatrics and Genetics, LLC to use and / or disclose information about yourself and the patient (or another person you have authorized to sign on your behalf) that is protected under federal law, for the sole purposes of treatment, payment and health care. You also agree to have us obtain patient's medication history from the pharmacy or Rx exchange.
You understand your rights under HIPAA. You may request a copy of this document at our office or view it on our website www.pediatricsgenetics.com. Privacy will be protected based on the Guardian / Guarantor details in this registration form. Any exceptions to these needs to be requested in writing.

Name of Guardian / Guarantor____________________________________ Patient Relationship______________

Signature ____ Date _____ / _____ /__________