PEDIATRIC PARTNERS, LLC - HOAGIE DRIVE

Patient Registration for Patients 18 Years of Age & Older
2018

Patient Name: _____ **Date of Birth:** _____ **Sex:** _____
Legal Last, First, MI – Also what you llike to be called.

Patient Social Security Number: _____

Address: _____

_____
Street or P.O. Box, City, State & Zip

Patient Primary Phone Number: _____ **Cell Phone Number:** _____
Patient Work Phone: _____
Patient Email: _____ **Work Email:** _____

Primary language spoken in the home? _____
Ethnicity: (Circle one) Hispanic Non-Hispanic Decline to Answer
Race: (Circle all that apply) American Indian Asian Black Hawaiian Native White
Decline to Answer

Privacy Constraints (Check One):
_____ No Restrictions: Okay to leave message/send mail.
_____ Restrictions: Person to person with patient only.
_____ Restrictions: _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email
Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email
Recall: Home Address / Home Phone / Work Phone / Cell Phone / Home Email
Billing Statements: Home Address / Home Email / Work Email
General Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email
Patient Portal: Cell Phone / Home Email / Work Email

Billing statements sent to:
Name: _____ Social Security Number: _____
Relationship to Patient: _____
Address if different than patient address: _____

_____
Primary Phone Number: _____ Cell Phone Number: _____

Parent 1: Name: _____ Date of Birth: _____
Social Security Number: _____
Work Phone: _____ Cell Phone: _____
Parent's Email: _____ Work Email: _____
Employer: _____
Do you live with this parent (circle one)? Yes No Relationship to Patient: _____
Address if different than patient: _____
_____

Parent 2: Name: _____ Date of Birth: _____
Social Security Number: _____
Work Phone: _____ Cell Phone: _____
Parent's Email: _____ Work Email: _____
Employer: _____
Do you live with this parent (circle one)? Yes No Relationship to Patient: _____
Address if different than patient: _____
_____

Primary Insurance: _____
Policy Holder's Last Name: _____
Policy Holder's First Name & Middle Initial: _____
Policy Holder's Date of Birth: _____ Social Security #: _____
Policy ID #: _____ Policy Group #: _____ Copay: _____
Secondary Insurance: _____
Policy Holder's Last Name: _____
Policy Holder's First Name & Middle Initial: _____
Policy Holder's Date of Birth: _____ Social Security #: _____
Policy ID#: _____ Policy Group #: _____ Copay: _____

I authorize the release of any medical or other information necessary to process claims from PEDIATRIC PARTNERS, LLC. I also request payment of government benefits either to myself or to the party who accept assignment below. I fully understand that I am financially responsible for all charges and balances remaining from claims, including charges not covered or denied by my insurance. I have been offered a copy of the Notice of Privacy Practice (HIPPA).

_____ _____

Signature (Must be patient if 18 or older) **Date**