PAMPA
Patient Registration Form

PLEASE NOTE, THIS INFORMATION IS BEING REQUESTED TO IMPROVE INTAKE OF YOUR CHILD'S FAMILY MEDICAL HISTORY.
PLEASE BE ACCURATE, LEGIBLE, AND THOROUGH WHEN FILLING OUT THE INFORMATION

Child 1: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname:** _____

Child 2: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname:** _____

Child 3: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname:** _____

Child 4: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname**: _____

Child 5: Last Name: _____ **First Name:** _____ **MI:** _____

D.O.B.: ____ /____ /____ **Sex:** *M / F* **Resides with**: *Mom / Dad / Both / Other* _____ **Nickname**: _____

Parent / Guardian 1: Last Name: _____ First Name: _____ MI: _____

Relation to Patient: Biological Mother / Biological Father / Adoptive Mother / Adoptive Father / Step-Parent / Other *(Please Specify)*:_____

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Date of Birth:** _____ / _____ / _____

Mailing Address: _____
(Street or PO Box) (City) (State & Zip)

Can contact have access to patients records? YES / NO **Primarily resides with patient?** YES / NO / 50%

*__Email:__ _____@_____ **Employer:** _____

Circle One
*__Primary Phone__ (*Cell / Home):(_____) _____ - _____ Other Phone: (_____) _____ - _____

PAMPA *may send information regarding appointment reminders, prescription recalls, billing statements as well as general notices via email and/or text message. If you wish to opt out of these services* ***Initial Here*** _____

Parent / Guardian 2: Last Name: _____ First Name: _____ MI: _____

Relation to Patient: Biological Mother / Biological Father / Adoptive Mother / Adoptive Father / Step-Parent / Other *(Please Specify)*:_____

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Date of Birth:** _____ / _____ / _____

Mailing Address: _____
(If different than above) (Street or PO Box) (City) (State & Zip)

Can contact have access to patients records? YES / NO **Contact primarily resides with patient?** YES / NO / 50%

*__Email:__ _____@_____ **Employer:** _____

Circle One
*__Primary Phone__ (*Cell / Home):(_____) _____ - _____ Other Phone: (_____) _____ - _____

PAMPA *may send information regarding appointment reminders, prescription recalls, billing statements as well as general notices via email and/or text message. If you wish to opt out of these services* ***Initial Here*** _____

How did you originally hear about our practice?

(Friend/Neighbor) (Doctor) (Insurance) (Internet) (Other) _____

Insurance information:

Primary Policy: Insurance Carrier: _____ ID#: _____

Policy Holder: Name: _____ Birth Date: _____ /_____ /_____ Sex: M / F

*****If parents are divorced or separated please fill out this section*****

Is there a court order that restricts either parent from obtaining information related to the child(ren)'s medical handling and/or consenting to medical treatment on behalf of the patient(s)? ***Yes / No***

If yes, please briefly explain below and provide the supporting documents so they can be kept on file.
(It will be assumed both parents have "joint legal custody" unless there is an authorized document stating otherwise)

Emergency Contact, ******Other Than Parent(s)***:***

Name: _____ Relationship to Patient: _____ Phone:(_____) _____-_____

If necessary can this contact can have access to patients records and information? **YES / NO**

Financial/Privacy Policies (HIPAA)

(Initial) _____ I authorize PAMPA to treat the above-named child (children) and to release medical and billing information to the insurance company so that payment for charges can be processed.

(Initial) _____ I understand that for PAMPA to file my insurance, I must present a valid card at the time of each visit. If no proof of insurance is provided I must pay for the services rendered at the time of service.

(Initial) _____ I authorize my children to receive health services with the understanding that if our insurance or managed care company determines that any services provided are non-covered services, I will be billed and held responsible for services rendered. Co-pays, deductibles and co-insurance amounts are due at time of service. A billing fee of $15 a month will be applied to any balance not paid at time of service. ***(Initial)*** _____ I acknowledge the Administrative Fee (ASF) is a yearly fee intended to cover the cost of certain administrative services we may provide which are not covered by your insurance.

(Initial) _____ I acknowledge the cancellation policy which states that PAMPA requires a 24-hour cancellation notice for all well child checkup visits and consultations. A $25.00 fee will be assessed per child for any missed or cancelled appointments without appropriate notice. Your cancellation must be made during regular office hours. As always, emergencies and unforeseen circumstances are taken into consideration.

Authorized Signature: _____ *Date* _____

Printed Name: _____Relationship to child(ren) _____