PEDIATRIC REGISTRATION FORM

Date:_____ **Patient Number:_____**

PATIENT INFORMATION

First Name | Middle | Last Name | Nickname

Date of Birth | Sex | Social Security Number

Patient Address (Street, Route, Apt. No., Etc.) | Home Phone Number ( )

City | State | Zip Code | Cell Phone/Beeper/Pager No. ( )

Referring Physician | Primary Care Physician/Pediatrician Name | PCP Office Number

INSURANCE INFORMATION

Primary Insurance Company Name | Policy Number | Group/Plan Number

Insured's Name | Insured's Date of Birth | Relationship to Patient

Secondary Insurance Company Name | Policy Number | Group/Plan Number

Insured's Name | Insured's Date of Birth | Relationship to Patient

PARENT/GUARDIAN INFORMATION

Mother's Information	**Father's Information**
Name	Name
Mother's SS # DOB	Father's SS # DOB
Spouse's Name	Spouse's Name
Address City, ST, Zip	Address City, ST, Zip
Home Phone Number ( ) Cell/Pager Number ( )	Home Phone Number ( ) Cell/Pager Number ( )
Employer Name Work Phone Number ( )	Employer Name Work Phone Number ( )

Patient's name _____ DOB:_____

Appointment Policy

In order to provide the highest level of service and individualized care to our patients, we strive to maintain a timely schedule as much as possible. Unfortunately, there are certain situations and events which are beyond our control. During these times, we respectfully ask for your understanding and patience. Certainly there will be occasions on which your child is the recipient of some extra attention from the doctors or staff.

Since last minute cancellations, late appointments and missed appointments adversely affect our ability to maintain a timely schedule, we kindly ask that you observe the following office policies.

Cancellations – When canceling an appointment, please try to give at least 24 hours notice.
Missed Appointments – We reserve the right to assess a $25.00 No-Show fee.
Late Appointments - Please be on time for your appointment. If you are more than 15 minutes late for your scheduled appointment time, you may be asked to reschedule.

Insurance

Please remember that insurance is considered only a method of reimbursement to the physician for services you have received - making you ultimately responsible. If there are any questions regarding payments or insurance filing policies, please contact Cindy at our billing service Claims Rx (1-815-464-7706). **You are also responsible to know your insurance policy/coverage for well baby care and immunizations. Please contact them to verify if there are any limits and notify the office.**

Also I give consent to have my insurance company assign directly to DuMais Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Consent to Treat

I hereby consent to the treatment for the above listed child as the parent or legal guardian of the patient. I further understand that prior to services being rendered; I must submit in writing my approval for anyone else to bring in this child for services such as a grandparent and/or other relative.

Health Insurance Portability & Accountability Act (HIPPA)

I understand that, under HIPPA I have certain rights regarding my child's protected health information. I understand that this information can and will be used to conduct, plan and direct my child's treatment and to obtain payment from third-party payers. I have been offered/received the notice of information practices and understand my rights as the parent/legal guardian of the above named child. I understand and give consent for DuMais Pediatrics to use my child's protected health information (PHI). I further am aware that I may revoke this consent in writing at any time, except to the extent that the office has already taken action relying on this consent.

Signature of
Parent/Guardian_____Date_____

Patient Name _____ DOB:_____

Pharmacy Information

Pharmacy Name _____

Pharmacy Location _____

Pharmacy Phone # _____

I give permission for the medical staff to contact me at the following numbers regarding patient care, test results, prescriptions and billing questions.

Home # _____

Work # _____

Cell # _____

Answering Machine Yes No

I give permission to leave test results with the following people:

Name _____Relationship to Child_____

Name_____ Relationship to Child_____

Name_____ Relationship to Child_____

I give permission for the following people to bring in my child for diagnostic evaluation and treatment:

Name_____ Relationship to Child_____

Name_____ Relationship to Child_____

Name_____ Relationship to Child_____