REGISTRATION FORM

PATIENT INFORMATION

Patient name: _____
(Last) (First) (Middle)
Date of birth: _____ Male/Female SS#: _____

Address: _____
(Street/PO Box) (City & State) (Zip Code)

PRIMARY CONTACT

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

Name: _____ Date of birth: _____

Phone Number: _____ SS#: _____

Address (if different from above): _____
(Street/PO Box) (City & State) (Zip Code)
Email: _____

SECONDARY CONTACT

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

Name: _____ Date of birth: _____

Phone Number: _____ SS#: _____

Address (if different from above): _____
(Street/PO Box) (City & State) (Zip Code)
Email: _____

Emergency Contact Name (other than parent): _____ Relation: _____

Emergency Contact Phone: _____
*The indicated emergency contact has permission for emergency medical information only.

PHARMACY

Pharmacy name: _____ Location/Cross streets_____

PRIMARY CARE PROVIDER

Doctor/Nurse Practitioner/Practice _____

PRIMARY INSURANCE

*If you have your card available, you may skip this section

Primary Insurance Name_____ Phone Number: _____

Claims Address: _____

Member ID: _____ Group #: _____

Insurance Carrier: _____ Relation to patient: _____

Carrier's SS#: _____ Phone Number: _____

SECONDARY INSURANCE

Secondary Insurance Name_____ Phone Number: _____

Claims Address: _____

Member ID: _____ Group #: _____

Insurance Carrier: _____ Relation to patient: _____

Carrier's SS#: _____ Phone Number: _____

GUARANTOR/FINANCIAL RESPONSIBILITY PARTY

☐ Primary Contact ☐ Secondary Contact ☐ Other: _____

Name: _____ Date of birth: _____

Phone Number: _____ SS#: _____

Address: _____
(Street/PO Box) (City & State) (Zip Code)

Email: _____

RELEASE OF INFORMATION/AUTHORIZATION TO TREAT

I understand that I am giving the following person(s) permission to schedule, bring in and have access to medical and/or financial information ONLY for the dates they accompany my child.

*Individuals listed may be granted access to specific financial and/or medical information ONLY if indicated below.

Name: _____ Relation to patient: _____

Phone Number: _____

Additional Information To Be Released: _____

Name: _____ Relation to patient: _____

Phone Number: _____

Additional Information To Be Released: _____

PLEASE READ CAREFULLY AND INITIAL

_____ I understand the above release will stay in effect until a change is requested in writing. I understand both biological parents have access to full disclosure (even non-custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. If those court orders exist, I must present current copies for my child's file.

_____ I have reviewed and agreed to the Financial Policy, which states that I am financially responsible for any balance not covered by my insurance carrier. I understand that my coverage is determined by an agreement I have made with my insurance carrier and that insurance denials do not reflect the opinions of Stellar Pediatric Urgent Care.

_____ I have been provided the office policies to read. I understand that I may receive additional copies of any policy upon request.

_____ I understand that my insurance card, and photo ID are required at the check-in window as well as any copay and/or past due balance past due on my account.

_____ I understand that a fee may be assessed for missed appointments, and dismissal may be considered for high missed appointment volume, as per office policy.

_____ I do herby give permission for medical treatment from a provider at Stellar Pediatric Urgent Care. I consent to any diagnostic testing or recommended procedures by the medical provider.

_____I have read and agree to the policies of Stellar Pediatric Urgent Care. I consent to the treatment of my child as well as the use and disclosure of my child's Protected Health Information (PHI) to carry out Third Party Operations (TPO) as outlined in our office Privacy Policy. I attest to the information I have provided is true and correct.

Signature of Parent/Legal Guardian: _____ Date: _____