2019
Patient Registration Form

Date ________________ **** We will need your driver's license and insurance card at each visit. ****

Patient Information

____ ❑ M ❑ F

Child Last Name First Name Preferred Name Date of Birth

Race: ❑ African-American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Native American

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown ❑ Declined Primary Language: ❑ English ❑ Spanish ❑ Other _________

Mother/Parent/Guardian #1 Information

Parent #1 Last Name First Name Date of Birth Relationship to child

Address City State Zip

Home Phone Cell Phone E-mail address

Father/Parent/Guardian #2 Information

Parent #2 Last Name First Name Date of Birth Relationship to child

Address (if different from above)

Home Phone Cell Phone E-mail address

May parent #2 have electronic access to this child's records? ❑ Yes ❑ No

If parents are divorced/separated, who has custody? ______________ Are there any legal restrictions on the non-custodial parent consenting to treatment or receiving medical information? ❑ Yes ❑ No If so, you must provide us a copy of the legal paperwork.

Insurance Information ** Please present all insurance cards to the front desk staff member*

❑ No insurance/self-pay ❑ Insurance Company:______________________________ ID # ________________ Group #_________

Name of Subscriber: ____________________________________ DOB _____________ Sex M F Relationship to child: ___________

Please initial one of the following:

________ **This is the only insurance plan my child has.**

________ **My child has secondary or another insurance plan**. **Ask for & complete Update/Additional Insurance form**.

Other

Emergency Contact: ______________________________ Relationship to child: ____

Preferred Pharmacy: __________________ Location: ____

Other

How did you hear about us? Who can we thank for referring you to us? ____

____
Initials

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Patient Registration Form page 2

Date ________________

Patient Information

_______________________________ _______________________________

Child's Name Date of Birth

Siblings (ask for additional sheet if necessary)

Child's Name	DOB	Sex
		M F
		M F

Child's Name	DOB	Sex
		M F
		M F

Sharing Information

❑ **If anyone other than a guardian may bring your child to the office, ask for & complete Alternate Caregiver Form.**

Please check the information below that you authorize us to release for the above patient, and who has permission to receive this information, other than the patient's parents/guardians:

❑ Billing information ❑ Medical information

_______________________________ _______________________________

Name of persons who have permission to receive information Relationship to patient

Communication Authorization

I authorize Covenant Care Pediatrics to leave a message regarding:

❑ All information including appointments, billing, updates, and/or general information ❑ Appointment information only

Communication Preferences

Mother/Parent/Guardian #1: How would you prefer to be contacted regarding: ❑ See form for other child: _______________

Medical Issues:	☐ Mail @ home	☐ Home Phone	☐ Text Message	☐ Call cell phone	☐ Home email
Appointment Reminders:	☐ Mail @ home	☐ Home Phone	☐ Text Message	☐ Call cell phone	☐ Home email
Recall Notices:	☐ Mail @ home	☐ Home Phone	☐ Text Message	☐ Call cell phone	☐ Home email
Billing Statements:	☐ Mail @ home			☐ Call cell phone	☐ Home email
General Practice Notices:	☐ Mail @ home	☐ Home Phone	☐ Text Message	☐ Call cell phone	☐ Home email
Patient Portal Notifications:				☐ Call cell phone	☐ Home email

Father/Parent/Guardian # 2: How would you prefer to be contacted regarding: ❑ See form for other child: _______________

Medical Issues:	☐ Mail @ home	☐ Home Phone	☐ Text Message	☐ Call cell phone	☐ Home email
Appointment Reminders:	☐ Mail @ home	☐ Home Phone	☐ Text Message	☐ Call cell phone	☐ Home email
Recall Notices:	☐ Mail @ home	☐ Home Phone	☐ Text Message	☐ Call cell phone	☐ Home email
Billing Statements:	☐ Mail @ home			☐ Call cell phone	☐ Home email
General Practice Notices:	☐ Mail @ home	☐ Home Phone	☐ Text Message	☐ Call cell phone	☐ Home email
Patient Portal Notifications:				☐ Call cell phone	☐ Home email

_______________________ _______________ _______________________

Signature Date Relationship to patient