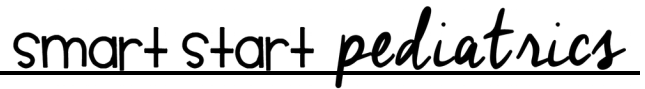


# PATIENT REGISTRATION



Patient's Legal Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street & Apartment # City State Zip Code

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

<b>We are required to collect the following information for each patient. Please complete this section before returning the form.</b>	
Preferred Provider: _____	Sex (Circle): M F
Your Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Haitian/Haitian Creole <input type="checkbox"/> Other: _____	
Your Child's Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian Native or Pacific Islander <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Multiracial <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other _____	
Your Child's Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other _____	

**Parent/Legal Guardian:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_

**Parent/Legal Guardian:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_

-----  
PRIMARY INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient's Relationship to Policy Holder: \_\_\_\_\_ Copay:  Yes  No Amount: \_\_\_\_\_

SECONDARY INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient's Relationship to Policy Holder: \_\_\_\_\_ Copay:  Yes  No Amount: \_\_\_\_\_

I agree that the above information is true and correct to the best of my knowledge. I authorize Smart Start Pediatrics LLC and its personnel to treat my child and consent to all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This delegation shall be valid until I withdraw my delegation of consent in writing.

\_\_\_\_\_  
Print Name (Patient or Guardian if minor)

\_\_\_\_\_  
Signature (Patient or Guardian if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Above Patient

Delegation of Consent for Minor Children

Please list all of your children who attend Smart Start Pediatrics below:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, Print name of biological parent or legal guardian authorize the following people to bring my child(ren) in for treatment and to consent to any and all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This delegation shall be valid until I withdraw my delegation of consent in writing.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child(ren): \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child(ren): \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child(ren): \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child(ren): \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child(ren): \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child(ren): \_\_\_\_\_

**Please Note:** The individuals listed above are the **ONLY** people (other than biological parents or legal guardians) authorized to bring your child(ren) to the doctor.

\_\_\_\_\_  
Print name of biological parent or legal guardian

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature of biological parent or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
translator/reader (if applicable)