PATIENT REGISTRATION

smart start pediatrics

Patient's Legal Name: _____
Last First Middle

Date of Birth:_____ Social Security #: _____

Address: _____
Street & Apartment # City State Zip Code

Home Phone: (_____) _____ Cell phone: (_____) _____

Email: _____

We are required to collect the following information for each patient. Please complete this section before returning the form.

Preferred Provider: | Sex (Circle): M F Other _____

Your Preferred Language: English Spanish Haitian/Haitian Creole Other: _____

Your Child's Race: American Indian/Alaskan Native Asian Black/African American Hawaiian Native or Pacific Islander Hispanic or Latino White Multiracial Unknown Decline to Answer Other_____

Your Child's Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Decline to Answer Other _____

Are there any religious or cultural beliefs that may impact your healthcare? If yes, please explain: _____

Level of education of parent/guardian: _____

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

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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, _____, 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.

Print name of biological parent or legal guardian

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)