ONE pediatrics℠

PATIENT REGISTRATION

Patient Name (First, MI, Last) _____ DOB _____

Preferred Name (Ex: Christopher "Chris") _____ Patient Social Security # _____

Address _____

City, State, Zip _____ Gender: MALE FEMALE

Race _____ Ethnicity: NON-HISPANIC HISPANIC DECLINE TO ANSWER

Primary Language Spoken in the Home _____

Pharmacy _____ Address _____

How Did You Hear About Our Practice? _____

Emergency Contact (Outside of the Home) _____ Phone _____

Other Children in the Home That Are Patients of This Practice _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

Name _____

Relationship to Child _____

DOB _____ SSN _____

☐ Same as Patient

Address _____

_____

Primary Phone _____

Cell _____ Daytime _____

Employer _____

Name _____

Relationship to Child _____

DOB _____ SSN _____

☐ Same as Patient

Address _____

_____

Primary Phone _____

Cell _____ Daytime _____

Employer _____

Email (For Patient Portal) _____

If Parents Are Divorced Or Separated, Please Complete The Following Section.

Who Has Primary Custody? _____

Are there any legal restrictions that would keep the non-custodial parent from consenting to medical treatment for the child, or from obtaining information about the child's medical treatment? YES NO

If yes, please explain, and provide our office a copy of any legal paperwork that supports this restriction. _____

_____

_____

CONTINUE TO BACK →

INSURANCE INFORMATION

Primary Insurance _____ Employer _____

Member / Subscriber ID# _____ Group# _____

Subscriber's Name _____ DOB _____

Subscriber's SSN _____ Relationship to Patient _____

Secondary Insurance _____ Employer _____

Member / Subscriber ID# _____ Group# _____

Subscriber's Name _____ DOB _____

Subscriber's SSN _____ Relationship to Patient _____

CONTACT PREFERENCES

☐ Cell Phone (text)

☐ Email Address

☐ Postal Mail

☐ Appointment Reminders

☐ Statements

☐ Telephone: Is it ok to leave message? YES NO

I authorize the release of any medical information needed to determine medical benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby consent to routine diagnostic procedures and medical treatment provided through Prospect Pediatrics and understand that no guarantee of results has been made.

Signature _____ Date _____

ONE Pediatrics, PLLC: All Star Pediatrics, Pediatrics of Bullitt County, East Louisville Pediatrics, Prospect Pediatrics, South Louisville Pediatrics, Springs Pediatrics, Kaplan Barron Pediatric Group, Oldham County Pediatrics, and Growing Kids Pediatrics.