Black & Benton Pediatrics

18 Year Old and Up Patient Registration Form

Chart #: _____

Date Updated: _____

Patient Information

Last Name: _____

First Name: _____ Middle Name: _____

DOB: _____ SS#: _____

Phone Number: _____

Sex: □ Male □ Female Race: _____ Hispanic: □ Y or □ N

Patient Address: _____

City: _____ State: _____ Zip: _____

Patient lives with: □ Mother □ Father □ Both □Other_____

Mother/Guardian's Information

Last Name: _____

First Name: _____ MI: ____

Street Address:

_____

City: _____ State: _____ Zip: _____

Primary Phone #: _____

SS#: _____ DOB: _____

Marital Status (Please check one):

□ Single □ Married □ Divorced □ Separated □ Widowed

Occupation: _____

Name of Employer: _____

Father/Guardian's Information

Last Name: _____

First Name: _____ MI: ____

Street Address:

_____

City: _____ State: _____ Zip: _____

Primary Phone #: _____

SS#: _____ DOB: _____

Marital Status (Please check one):

□ Single □ Married □ Divorced □ Separated □ Widowed

Occupation: _____

Name of Employer: _____

18 Year Old & Up Please Read & Sign

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or inquire about appointment status without my specific written permission. Black and Benton Pediatrics will not release medical information to my parents without my written authorization in accordance with this document.

_____**I DO NOT** grant access to my parents and/or guardians. No medical information, records, or appointment status information can be discussed or released.

_____**I WISH TO** grant the following individuals access to my healthcare providers and/or medical information:

1) Name: _____

   Relationship: _____

2) Name: _____

   Relationship: _____

Patient Signature *(please sign):*

➔_____

Emergency Contact

Please list a friend/relative that does not live with you.

Name: _____

Primary Phone #: _____

Relationship: _____

Primary Insurance Information

Name of Insurance: _____

Policy Holder: _____ DOB: _____

ID#: _____ Group#: _____

Secondary Insurance Information

Name of Insurance: _____

Policy Holder: _____ DOB: _____

ID#: _____ Group#: _____

Pharmacy Information:

Name: _____

Phone Number: _____