Front Porch Pediatrics

PEDIATRIC PATIENT REGISTRATION FORM

Patient Information

Last, Middle, First	Social Security #	Gender Preference ☐ M ☐ F ☐ Transgender (M to F) ☐ Transgender (F to M)	Date of Birth (MM/DD/YY)

Patient Race/Ethnicity – Select all that apply.

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other

Is the patient Hispanic? ☐ Yes ☐ No

Emergency Contact Name	Relationship to Patient	Emergency Contact Phone

Parent / Guardian Information

Mother/Guardian Name		Mother/Guardian Email Address		
Mother/Guardian Address		City	State	ZIP
Mother/Guardian Primary Phone	Date of Birth	Occupation		
Father/Guardian Name		Father/Guardian Email Address		
Father/Guardian Address		City	State	ZIP
Father/Guardian Primary Phone	Date of Birth	Occupation		

Insurance & Guarantor Information

Primary Insurance	Policy #	Group #
Subscriber Name	Relationship to Patient	
Secondary Insurance (If applicable)	Policy #	Group #
Subscriber Name	Relationship to Patient	
Guarantor/Name of Person Responsible for Payment (If different from Subscriber)		
Address	City	State / ZIP
Phone	Relationship to Patient	

Parent/Guardian Signature	Relationship to Patient	Date

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Authorization and Agreement for Treatment

Patient Name	Date of Birth (MM/DD/YY)

The undersigned hereby makes the acknowledgements and agreements regarding the treatment to be provided to the patient whose name appears on the Registration Form. The patient, guardian, or patient representative must initial all applicable items.

Consent for Treatment

_____ I certify that I am requesting examination and medical treatment of the patient by the physicians and employees of
(initials) Front Porch Pediatrics. I give permission for evaluation and treatment and certify that no guarantee or assurance has been made as to the results that may be obtained. If the patient is a minor, I understand that a parent, legal guardian, or responsible adult must accompany the patient to the health center and stay with the patient throughout the entire examination.

Financial Agreement and Assignment of Benefits

_____ I acknowledge that I have received a copy of the Front Porch Pediatrics Financial Policy and that I agree to abide by its
(initials) terms.

Patient's Bill of Rights and Responsibilities

_____ I acknowledge that I have received a copy of the Front Porch Pediatrics Patient's Bill of Rights and Responsibilities and
(initials) that I agree to abide by its terms.

Notice of Privacy Practices

_____ I acknowledge that I have received a copy of Front Porch Pediatrics Notice of Privacy Practices.
(initials)

Release of Medical Information

_____ (If applicable) In addition to the use and/or disclosure of my PHI as stated above, I authorize my information to be
(initials) released to the following individual(s). Please provide full name(s) of authorized individual(s) below. I understand that this request will not restrict the normal use or disclosure of PHI as stated above.

Name of Authorized Person	Relationship to Patient

_____ I consent to SMS text or Voice messaging regarding appointments

_____ I understand that I may amend or revoke my consent to use and/or disclosure of PHI at any time, if submitted in
(initials) writing. Use or disclosure that occurs prior to the date on which the revocation of consent is received will not be affected.

I have read and fully understand the above acknowledgments and agreements.

Patient/Guardian Signature	Relationship to Patient	Date

Office Use Only	
Employee Signature	Date

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List of Authorized Persons for Medical Purposes

I, _____, the parent or legal guardian of
Parent/Legal Guardian Name

_____, hereby authorize the individual(s)
Child's Name and Date of Birth

listed below to act as temporary guardian(s) for the purpose of bringing my child to Front Porch Pediatrics These individuals have permission to bring my child into the clinic and consent to healthcare treatments and examinations in my absence.

Parent/Guardian Signature	**Relationship to Patient**	**Date**

Office Use Only	
Employee signature	Date

Release of Information Request Form

Formulario de solicitud de divulgación de información

Release To: Front Porch Pediatrics

Obtain From:_____
(Obtener de)

Address:_____
(DIRECCIÓN)

Re: Patient Name:_____ Date of Birth_____
(Nombre del paciente) (Fecha de nacimiento)

Purpose for release:_____
(Propósito)

_____

☐ All Medical Records (Todos los registros médicos)
☐ Other (otro)

* I hereby authorize Front Porch Pediatrics to ☐ obtain / ☐ release the above information regarding myself or my dependent, above named.

(Por la presente autorizo a Front Porch Pediatrics a ☐ obtener/ ☐ divulgar la información anterior sobre mí o mi dependiente, arriba mencionado.)

* It is further understood that this release is subject to revocation at any time in writing, and unless otherwise specified hereinafter, automatically expires in 360 days from the signature date.

(Se entiende además que este comunicado está sujeto a revocación en cualquier momento por escrito, y a menos que se indique lo contrario.
Especificado a continuación, vence automáticamente a los 360 días a partir de la fecha de la firma.)

_____ _____ _____

Signature of Patient /Guardian (Firma del paciente / tutor) | Relationship to Patient (Relación con el paciente) | Date (Fecha)

Employee Initials

_____