Please use: BLACK INK

Northwest Pediatric Center

Please include all children who have the same biological parents and live in the same household on one Registration Form

	Child – #	Child – #	Child – #	Child – #
First Name				
Middle Initial				
Last Name				
Birthdate	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Sex	_____ Male _____Female	_____ Male _____Female	_____ Male _____Female	_____ Male _____Female
Gender Identity				
Orientation				
Primary Language Spoken	___ English ___ Spanish List Other_____	___ English ___ Spanish List Other_____	___ English ___ Spanish List Other_____	___ English ___ Spanish List Other_____
Ethnicity	___ Not Hispanic ___Hispanic ___ Unknown	___ Not Hispanic ___Hispanic ___ Unknown	___ Not Hispanic ___Hispanic ___ Unknown	___ Not Hispanic ___Hispanic ___ Unknown
Race check all that apply	___ White ___ Native American ___ Black ___ Asian ___ Pacific Islander	___ White ___ Native American ___ Black ___ Asian ___ Pacific Islander	___ White ___ Native American ___ Black ___ Asian ___ Pacific Islander	___ White ___ Native American ___ Black ___ Asian ___ Pacific Islander
School				

Parent/Guardian 1 Do you live with patient(s)? Yes _____ No _____ (primary contact will be the preferred contact person for appt reminders)

Language**: _____** **Check one**: ___ Biological Mother ___ Step-Mother ___ Adoptive Mother ___ Foster Mother ___ Legal Guardian
___ Biological Father ___ Step-Father ___ Adoptive Father ___ Foster Father Other:_____

Name:_____
First M.I. Last Social Security Number DOB

Mailing Address: _____
Street City State Zip Code

Employer: _____ Occupation: _____

Email Address: _____ Would you like access to your child's medical record through our Patient Portal? Yes_____ No_____

Primary Contact Number: _____ Is this a _____ Cell Phone _____ Home Phone
Secondary Contact Number: _____ Is this a _____ Cell Phone _____ Home Phone
How would you like appointment reminders & recalls? Email _____ Text to Cell _____

Parent/Guardian 2 Do you live with patient(s)? Yes ____ No ____

Language**: _____** **Check one**: ___ Biological Mother ___ Step-Mother ___ Adoptive Mother ___ Foster Mother ___ Legal Guardian
___ Biological Father ___ Step-Father ___ Adoptive Father ___ Foster Father Other:_____

Name:_____
First M.I. Last Social Security Number DOB

Mailing Address: _____
Street City State Zip Code

Employer: _____ Occupation: _____

Email Address: _____ Would you like access to your child's medical record through our Patient Portal? Yes_____ No_____

Primary Contact Number: _____ Is this a _____ Cell Phone _____ Home Phone
Secondary Contact Number: _____ Is this a _____ Cell Phone _____ Home Phone
How would you like appointment reminders & recalls? Email _____ Text to Cell _____
WHO IS CUSTODIAL PARENT? (If applicable) _____

Please provide a copy of any documents related to custodial rights for the patient's record

In order to obtain more accurate Family Medical History Requirements, if contacts listed above are NOT the **BIOLOGICAL PARENTS**, it is now necessary for **BOTH BIOLOGICAL PARENTS** (if known) to be listed:
Biological Mother _____ Date of Birth _____

Biological Father _____ Date of Birth _____

IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT YOU WILL BE CONSIDERED SELF PAY

Is patient(s) covered by Apple Health or Provider One? _____ Yes _____ No

Primary Insurance

Subscribers Name: _____ Subscribers DOB: _____/_____/_____
Relationship to Patient: _____
Name of Insurance Company: _____
Employer (Group) Name: _____
Subscriber ID#: _____ Group #: _____

Secondary Insurance

Subscribers Name: _____ Subscribers DOB: _____/_____/_____
Relationship to Patient: _____
Name of Insurance Company: _____
Employer (Group) Name: _____
Subscriber ID#: _____ Group #: _____

Emergency Contact: _____ Relationship to Patient _____ Phone: _____
(Other than contacts listed on front – enter Friend or relative not living with you)

Case worker: (If applicable) Case Worker name and phone number: _____

Authorized Adult(s): I, _____, as the legal guardian of the above named patient hereby give permission for the following persons to authorize the medial care indicated below for the said patient.

Authorized Adult _____ Relationship _____
Authorized Adult _____ Relationship _____
Authorized Adult _____ Relationship _____

Permission is granted from this date forward until written notice is given of change. The above named adults have my permission to authorize the following treatments indicated for said patient office visits and indicated treatments(s)

- Emergency visits and indicated treatment(s)
- Vaccinations
- Lab work
- Therapeutic injections (e.g. Allergy injections, Depo=Provera injections, antibiotic injections, etc.)

Signature of Parent or Legal Guardian: _____ **Date** _____

HIPAA Privacy Practices: I acknowledge that Physician's Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician/provider has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me.

Signature of Parent or Legal Guardian: _____ **Date** _____

Financial Responsibility

I understand that I am financially responsible for all charges, regardless of my insurance coverage. It is my responsibility to notify NWPC of my insurance at each visit and to update NWPC when I have a change. If my insurance requires a copay, that copay must be paid at the time of service. I understand that I am responsible for any amount not covered by my insurance plan. If I do not have insurance, payment is required at the time of service unless other arrangements have been made in advance with the billing department. If it becomes necessary for NWPC to turn my account over to a collection agency on of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby assign to the physician/provider all payments for medical services rendered. I hereby authorize Northwest Pediatric Center to release information necessary to secure payment of benefits. I have read the above policy.

Signature of Parent/legal guardian: _____ Date: _____

Print Name: _____

Preferred Pharmacy: _____ Location: _____

updated _____