

PATIENT REGISTRATION
Established Patient - Yearly Update

PATIENT

Last Name _____ First Name _____ MI _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ DOB _____ Sex: M F
Guardian if other than parent _____, Additional Siblings:
1) Name: _____ DOB: _____ 2) Name: _____ DOB: _____
3) Name: _____ DOB: _____ 4) Name: _____ DOB: _____

PARENTS

Mom's Last Name _____ First Name _____ MI _____
Same address as patient? Y N If no please fill in below
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____

Dad's Last Name _____ First Name _____ MI _____
Street address same as patient? Y N If no please fill in below
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____

EMAIL ADDRESS (mom or dad) _____
EMERGENCY CONTACT _____ Phone _____

STEP PARENTS _____

Financial Agreement

I the parent/guardian am requesting that the providers at Children's Oasis Pediatrics see the above named child for Well Child Check/Acute Care. The above named patient has:

Name of Guarantor: _____ DOB: _____

Private Insurance No / Yes

If Yes: Primary Ins: _____ Secondary Ins: _____

State Fund Insurance No / Yes Primary or Secondary

If Yes: Ins: _____

By signing this form I'm telling Children's Oasis Pediatrics that this child/children have the insurance listed above and no other. I am aware that this office will not be held accountable if found that the parent/guardian has falsified the above insurance information after claims have been submitted. If it is found later that the insurance information was incorrect, the patient will be responsible for the original decision by the insurance that was billed.

Signature of Parent/Guardian

Date

Patient Consent for Use and Disclosure of Protected Health Information and Office Policy

As parent/guardian of _____, I understand that as part of my child/children's health care Children's Oasis Pediatrics originates and maintains health records. These records describe history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I also give my consent for the patient(s) to receive medical evaluation and treatment by the providers at Children's Oasis Pediatrics. (I have been provided the opportunity to view the Notice of Information Practices that describes uses and disclosures of my child's Protected Health Information (medical record). I understand that I have the right to review the notice prior to signing this consent.)

With my consent, Children's Oasis Pediatrics may call (including leaving voice mail messages) or mail my home regarding items that assist the practice in carrying out treatment, payment, and health care operations, such as an appointment reminders, normal laboratory results and insurance items.

I understand that Children's Oasis Pediatrics has the right to change its notice and practices. I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations and that Children's Oasis Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Children's Oasis Pediatrics has already taken action. If I do not sign this consent or revoke it, Children's Oasis Pediatrics may decline to provide treatment to my child.

I am aware that according to my insurance plan I am responsible for all co-payments, deductibles, and co-insurance. Co-payments are due at the time of the service. Not all services are covered by every plan. It is my responsibility as the guarantor/parent/guardian to understand and have knowledge of my insurance plan. **Any service not covered by my plan will be my responsibility.** I am aware if my account is not paid and sent to collections, the patient(s) will be asked to find another provider. The office does ask that I give a 24 hour notice if I need to cancel or reschedule. No Show will apply to visits that are missed with a \$20 fee.

I fully understand and I consent to Children's Oasis Pediatrics' use and disclosure of my children(s) Protected Health Information in order to carry out treatment, payment and health care operations. I also fully understand and consent to Children's Oasis Pediatrics' office policy.

In My Absence

I, being the parent/legal guardian of the above named minor(s), do hereby give permission to the following individual(s) to act on my behalf in authorizing medical care for the above named minor(s) during my absence. I also authorize Children's Oasis Pediatrics to discuss my child(s) care with the following people.

Name	Relationship to child	Phone Number	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian (print)

Signature

Date