**PEDIATRIC HEALTHCARE, LLC**
**4700 Woodmere Boulevard, Montgomery, AL 36106**
**Phone: 334-273-9700 Fax: 334-273-9788**

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# PATIENT REGISTRATION FORM

**(PLEASE PRINT ALL INFORMATION)**

My Primary Care Physician is Dr. _____ Date: _____

**PATIENT INFORMATION:**

Patient's Legal Name: _____ Goes By: _____

Patient's Date of Birth: _____ Gender: M F Social Security No: _____ Religion: _____

Whom may we thank for referring you to our office? _____

Name of Child's Brothers and Sisters: _____

_____

**PARENT INFORMATION:** **FAMILY E-MAIL ADDRESS:** _____

**Mother's Name**: _____ Goes By: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security No: _____ Marital Status: Married Single Divorced Widowed

Employer: _____ Occupation: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

**Father's Name**: _____ Goes By: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security No: _____ Marital Status: Married Single Divorced Widowed

Employer: _____ Occupation: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

**Legal Guardian (Name and Address)**: _____

_____

**EMERGENCY CONTACT (other than parents):**

Name: _____ Daytime Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Due to the HIPAA (Health Insurance Portability and Accountability Act of 1966) Privacy Regulations, Pediatric Healthcare needs to know to whom we are authorized to release your child's protected health information (PHI).

- ☐ Check here if we are authorized to leave information on your answering machine.

  Pediatric Healthcare is authorized to release the protected health information of my children to those listed below. I understand that I may change this in writing at any time.

  _____

  _____

  _____

***My signature authorizes payment of health insurance benefits for covered services rendered directly to the listed physician. I further understand that I am responsible for all charges not covered by my health insurance. I give permission to the above physician and their employees to provide the requested and necessary care to my child.***

**Guarantor's Signature:** _____ **Relationship to Patient:** _____

**Witness:** _____ **Date:** _____