

Patient name _____ Date of Birth _____ Sex (M or F) _____ Patient's Social Security Number _____

Parent / Legal Guardian Information

Mother Father Stepmother Stepfather Foster Mother Foster Father Other: _____

Name _____ Maiden Name _____ Date of Birth _____ Social Security Number _____

Street address and P.O. Box, if applicable _____ City _____ State _____ Zip code _____

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Home Phone _____ Email Address _____

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Mobile Phone _____ Work Phone _____

Employer _____

Employer Address _____

Best Contact Number

Home Work Mobile (OK to Send Text Messages)

Custody Information (Complete when are separated)

- Joint legal and physical
- Joint legal with physical custody retained by:
 - Mother Father
- Sole legal and physical custody
- No formal custody arrangements
- Lives independently

Has Medical Records Access been restricted?

Yes (Legal Documentation Required)

Parent / Legal Guardian Information / Other

Mother Father Stepmother Stepfather Foster Mother Foster Father Other: _____

Name _____ Maiden Name _____ Date of Birth _____ Social Security Number _____

Street address and P.O. Box, if applicable _____ City _____ State _____ Zip code _____

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Home Phone _____ Email Address _____

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Mobile Phone _____ Work Phone _____

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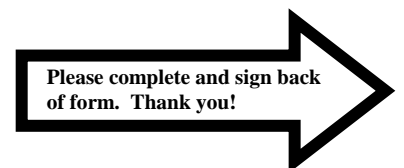
Home Work Mobile (OK to Send Text Messages)

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- Sole legal and physical custody
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Has Medical Records Access been restricted?

Yes (Legal Documentation Required)



INITIAL _____ DATE _____



Annual Patient Registration and Information
Please complete all information.

Patient name _____ Date of Birth _____ Sex (M or F) _____ Patient's Social Security Number _____

Emergency Contact (Not Parent or Guardian)

1. Name _____ Relationship to Patient _____

Street address and P.O. Box, if applicable _____ City _____ State _____ Zip code _____

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Home Phone Work Phone Mobile Phone OK to Send Text Messages

2. Name _____ Relationship to Patient _____

Street address and P.O. Box, if applicable _____ City _____ State _____ Zip code _____

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Home Phone Work Phone Mobile Phone OK to Send Text Messages

Insurance Information (Not required if Insurance card is presented today)

Commercial Plan Medicaid Plan No Insurance

Insurance Carrier _____ Subscriber Name _____ Subscriber Date of Birth _____
Relationship to Patient _____ Commercial Plan
 Medicaid Plan

ID / Policy Number _____ Group Number _____ Phone Number (On Back of Card) _____

Permission to Treat Without Parent/Guardian Accompanying Child (Please use our full permission to treat form if limitations are needed)

Piedmont Pediatrics must receive permission from a child's parent or legal guardian before providing treatment for an injury or illness that is non-life threatening. If this information is not on file with us or presented by the adult accompanying your child (baby-sitter, relative, friend), Piedmont Pediatrics will contact the child's parent or legal guardian before he or she is seen by the physician. If permission is not received, care may not be provided.

I give consent by proxy to the individuals listed below, as my proxy decision maker(s) for consenting to non-urgent medical care for my child(ren) listed above. I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. I understand that protected patient health information may be shared with the proxy(s) to whom the right to consent has been delegated to facilitate informed decision making.

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Name Phone Number Relationship to Patient(s)

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Name Phone Number Relationship to Patient(s)

I certify that I am the parent/legal guardian of this child and that all information provided on this registration form is true and accurate. I give consent to Piedmont Pediatrics, its medical staff and other providers involved in my care to use and/or disclose my protected health information for the purposes of treatment, payment and health care operations.

X _____
Guarantor (Parent/Guardian) **Date** **Relationship to Patient**