# Annual Patient Registration and Information

*Please complete all information.*

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

Home Phone | Email Address

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

Home Phone | Email Address

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)

**Please complete and sign back of form. Thank you!**

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

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

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 | ☐ Commercial Plan

Relationship to Patient | ☐ 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.**

Name | Phone Number | Relationship to Patient(s)

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