Step By Step Pediatrics, PC
Patient Registration

Patient Information

Chart/MR#_____

Patient Name_____ SSN_____

Sex: M F Date of Birth _____ Race/Ethnicity_____

Mother's Name_____ DoB_____SSN_____

Address_____ Home Phone_____

City/State/Zip_____ Cell Phone _____

Employer/Occupation_____ Work Phone_____

Father's Name_____ DoB_____SSN_____

Address_____ Home Phone_____

City/State/Zip_____ Cell Phone_____

Employer/Occupation_____ Work Phone_____

Email Address _____ Mother Father Other_____

Other Children in Family:
Name_____Sex: M F DoB_____SSN_____
Name_____Sex : M F DoB_____SSN_____
Name_____Sex: M F DoB_____SSN_____
Children live with: Mother Father Other_____

Emergency Contact Person_____Relationship_____Phone_____

Party Responsible for Payment of Medical Services: Father Mother Both Other_____

Who referred you to our office? _____

Insurance Information

Primary_____Claims Address_____
Policy #_____Group #_____Co-payment $_____
Secondary_____Claims Address_____
Policy #_____ Group #_____Co-payment $_____
Name of Insured_____DoB_____Relationship_____
Medicaid/Other_____Current Card #_____
Physician (PCP) name listed on Card_____Phone_____

Authorization of Treatment and Assignment of Benefits

I authorize Step By Step Pediatrics, PC to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Step By Step Pediatrics, PC for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not payable by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. If my unpaid balance is turned over to an outside collection agency, I understand that I am responsible for any and all applicable collection fees.
I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's Signature_____Relationship_____Date_____
Witness Signature_____Date_____

HIPAA Authorization Statement

Complete and sign the section below regarding confidential release of information.
Please complete the following so that we may contact you properly and securely.

 Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment, and health care options).

Name_____Phone_____

Name_____Phone_____

 Please list the family members or other persons, if any, who may, in your absence, accompany your child for medical care or immunizations.

Name_____Phone_____

Name_____Phone_____

 Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.
Name_____Phone_____
Name_____Phone_____

 Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home._____
_____

 Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number._____**(**Please be aware that a cell phone is not a secure and private means of communication.)

 Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? Yes No

 Please print your email address for office communication purposes only (we will not release this information to any outside party):_____

 Please list your preferred method of contact: Phone Mail Email

_____
Patient Name *print*

_____ Date_____
Parent/Guardian Signature

Notes:
_____
_____