PARTNERS IN CARE PEDIATRICS

PATIENT REGISTRAION FORM

PATIENT FULL NAME: _____

DOB:_____

Home address: _____

City:_____ State:_____ Zip: _____

Cell Phone :_____

Parent / Guardian full name: _____

DOB of parent: _____

Parent / guardian Email: _____

Emergency Contact

Emergency contact 1 name: _____

Phone number:_____

Relationship to patient: _____

Emergency contact 2 name: _____

Phone number: _____

Relationship to patient: _____

Pharmacy

Pharmacy name: _____

Address: _____

Phone number: _____

Sign:_____ Date:_____

7918 Braodway St, suite 108. Pearland, TX 77581. Ph: 281-857-6171. Fax: 281-783-2117
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Insurance Information

Name of primary Insurance: _____

Type of insurance (circle one): PPO HMO Medicaid Chip EPO

Insurance ID Number: _____

Main Subscriber name: _____

Date of birth of main subscriber: _____

Name of secondary Insurance: _____

Type of insurance (circle one): PPO HMO Medicaid Chip EPO

Insurance ID Number: _____

Main Subscriber name: _____

Date of birth of main subscriber: _____

Medical history

Any allergy to any medication?

_____

Any allergy to any food item?

_____

List patient current medications and doses:

_____

_____

_____

_____

Prior hospitalizations? If yes please explain why,

_____

_____

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ACKNOWLEDGEMENT AND AUTHORIZATION

I have read and understand the HIPAA/Privacy Policy for Partners In Care Pediatrics

Signed_____**Date:**_____

I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____**Date:**_____

I authorize Partners In Care Pediatrics to release medical information required to process my claim

Signed_____**Date:**_____

I authorize Partners In Care Pediatrics to obtain/have access to my medication history

Signed_____**Date:**_____

I authorize my provider's office to contact me by mobile phone

Signed_____Date:_____

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