The Kidz Docs Registration Form

Date_____ Patient's Primary Kidz Docs Provider_____

Patient Information

Last Name	First Name			MI
Date of Birth	Sex	Nickname		
Street Address	City, State, Zip Code			
Additional Patients in Family				
Last Name	First Name	MI	Date of Birth	Sex M F
Last Name	First Name	MI	Date of Birth	Sex M F
Last Name	First Name	MI	Date of Birth	Sex M F
Last Name	First Name	MI	Date of Birth	Sex M F

Mother's Name		Father's Name	
Street Address (if different from patient)	Check if same_____	Street Address (if different from patient)	Check if same_____
City, State, Zip Code		City, State, Zip Code	
Home Phone	Work Phone	Home Phone	Work Phone
Cell Phone	Email Address	Cell Phone	Email Address
Please check each method by which we may contact you: _____Home Phone _____Work Phone _____Cell Phone _____Email		Please check each method by which we may contact you: _____Home Phone _____Work Phone _____Cell Phone _____Email	
Occupation		Occupation	
Employer		Employer	

Emergency Contact (person not living with patient)

Name		Relationship
Home Phone	Cell Phone	Work Phone
Pharmacy Name		Location/Phone Number

The following people have my permission to bring my children to The Kidz Docs for medical care:

Name	Name
Name	Name
Name	Name

I understand that any person not on the above list must have written permission from a parent of guardian to bring a patient under the age of 18 to be seen for medical care at The Kidz Docs.

Patient Last Name	First Name

Responsible Party/Guarantor

Name	Relationship

Primary Insurance Information

Name of Insurance Company	Employer
Policy Holder (Subscriber) Last Name	First name

Relationship to Patient	SSN#	Date of Birth
Group Number	Policy Number	Effective Date

Secondary Insurance Information

Name of Insurance Company	Employer
Policy Holder (Subscriber) Last Name	First name

Relationship to Patient	SSN#	Date of Birth
Group Number	Policy Number	Effective Date

The following optional questions are a government mandate for healthcare providers to improve health care quality, safety, and efficiency through the promotion of health information technology.

Please check one:

Race _____American Indian/Alaska Native _____Asian _____Black/African American
_____Native Hawaiian or Other Pacific Islander _____Hispanic _____White _____Decline to Report

Please check one:

Ethnicity _____Hispanic or Latin American _____Not Hispanic or Latin American _____Decline to Report

Please check one:

Language _____English _____Spanish _____Russian _____Indian (includes Hindi and Tamil) _____Other_____

I authorize the providers at The Kidz Docs to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I have checked with my insurance company and have verified that The Kidz Docs is listed as a contracted provider for my child. _____(Please initial)

I authorize payment directly to The Kidz Docs for all medical benefits otherwise payable to me under the terms of my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. I certify that the information I have reported with regard to my insurance is correct. _____(Please initial)

I agree to pay for any and all medical services my child receives from The Kidz Docs. I understand that if my insurance company refuses to pay, for whatever reason, these fees will become my responsibility. I understand and agree to abide by the above policy. _____(Please initial)

By signing this notice below, you acknowledge that you are the child's parent, guardian, or other representative duly authorized to act on your child's behalf and that you have received a copy of The Kidz Docs Notice of Privacy Practices (HIPPA) and a copy of the office policies. _____(Please initial)

Parent/Guardian Signature_____**Relationship**_____**Date**_____

Patient Last Name	First Name

General Consent to Treat

I have the legal right to consent to medical and surgical treatment because I am the parent/guardian of the patient.

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at The Kidz Docs and their designated associates or assistants believe are necessary for the patient. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, physician's assistants, and other health care providers in the medical office to provide treatment as long as a physician/ patient relationhip exists, or until I withdraw my consent. _____(Please initial)

Sharing Records for Treatment
We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical system, they may have access to your medical record. _____(Please initial)

Voicemail and Text Notifications
As a service to our patients, The Kidz Docs provides courtesy appointment reminder calls/texts and possibly other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initaling below, you consent to receiving such calls/texts at the cell phone number you have provided to us. _____(Please initial)

Electronic Prescription (E-Prescribing)
I voluntarily authorize The Kidz Docs to allow E-Prescribing for presciptions, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information, and medication dispensing history as long as a physician/patient relationship exists, or until I withdraw my consent. _____(Please initial)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it. _____(Please initial)

Parent/Guardian Signature_____**Relationship**_____**Date**_____

Authorization to Release Information for Patients over 18 Years of Age

I, (print name)_____, understand that as a patient age 18 and older that my medical information will no longer automatically be shared with my parents. I acknowledge that I must give authorization to the providers and staff at The Kidz Docs to discuss my medical care and concerns with anyone other than myself.
CONFIDENTAL INFORMATION WILL NOT BE DISCUSSED WITH ANYONE (regardless of what is checked below)
Confidential information includes mental health, substance abuse, sexual health, sexually transmitted infection/ AIDS/HIV testing and results.
Please check one:
_____I *do not give* authorization for my medical information to be discussed with anyone other than myself.

_____I *give* authorization to the providers at The Kidz Docs to discuss my medical information with the people listed below:
Name_____Relationship_____
Name_____Relationship_____

Patient Signature_____ Date_____