Designated Choice for PCP_____

SANFORD PEDIATRICS REGISTRATION FORM

1801 Doctors Drive, Sanford, NC 27330 Today's Date: _____

PATIENT NAME_____
(last) (first) (middle)

DATE OF BIRTH_____ Sex_____ Email address _____

PREFERRED LANGUAGE _____**RACE**_____**ETHNICITY** ☐ Hispanic/Latino **or** ☐ non-Hispanic/Latino

PHONE NUMBERS: Home _____ Cell _____ Preferred contact method: ☐ home ☐ cell ☐ email

RESPONSIBLE PERSON_____DOB:_____

Address_____ City_____ State _____Zip _____

#1 Preferred Contact (Custodian)_____Relationship_____

Phone # _____Employer_____Work #_____

#2 Preferred Contact_____Relationship_____

Phone # _____Employer_____Work #_____

EMERGENCY CONTACT (Other than above) _____ Relationship _____

Phone # _____Address: _____

BROTHERS AND SISTERS

INSURANCE INFORMATION

#1 Policy Holder_____Employer_____

Insurance Co._____ Claims Address_____

Policy #_____Group #_____

#2 Policy Holder_____Employer_____

Insurance Co._____ Claims Address_____

Policy #_____Group #_____

MEDICINE ALLERGIES: _____

AUTHORIZATIONS AND ACKNOWLEDGEMENTS OF PATIENT RIGHTS

_____ (initials) **PAYMENT AND RELEASE AUTHORIZATION.**"I hereby authorize Sanford Pediatrics, P.A. to release information acquired in the course of my examination and treatment. I hereby assign payment directed to the designated physician for any medical procedures performed. I understand I am responsible and will pay for any services not covered by my insurance company."

_____(initials) **PARENTAL/GUARANTOR PERMISSION TO TREAT "**I give permission for physicians of Sanford Pediatrics, P.A., or persons designated by them, to interview, examine and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above-named minor. Permission for evaluation and treatment is granted whether child is presented by parent, other family member, unrelated third party, or unaccompanied."

_____(initials**) ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY** "I acknowledge that I have been notified of my right to privacy by law regarding my "protected health information". I understand my information is being protected and have been informed of my rights and the practices responsibilities to protect my information.

SIGNATURE_____

(parent or guardian if patient is a minor)