Patient Registration Form

Child's Last Name:______________________ First Name________________MI: ___
Sex _____ Date of birth _________Mothers Maiden Name_______________________
Siblings: Name: _______________________ Name: __________________________
Name: _______________________ Name: __________________________

Race (check one)
___American Indian or Alaskan Native ___Asian ____Black
___Hawaiian Native or Pacific Islander ___White ____Prefer not to say

Ethnicity (check one):
___Unknown ___Hispanic or Latino ___Not Hispanic or Latino ____Prefer not to say

Permanent Billing /Mailing Address:

____
(Street or PO Box) (City) (State & Zip)

Parent 1: Name __________________________ Relationship to child______________
Date of birth ___________Occupation: _______________Employer: _______________
Mailing Address:

____
(If different from above) (Street address) (City) (State & Zip)
Home Phone: _____________________ Work phone __________________________
Cell Phone: _____________________ Parent's email: ________________________

Parent 2: Name __________________________ Relationship to child______________
Date of birth ____________Occupation: _____________Employer_________________
MailingAddress:____
Home Phone: ______________Work phone: ______________Cell:________________
Email: _______________________________________

Patient Phone numbers/addresses/email:
Preferred phone number: __________________ Alternate phone: _________________
Patient: Cell phone: __________________ Patient's email: ______________________

Both parents live with patient full time(circle one)? Yes / No
For separation or divorce, please explain any important living arrangement details :

____

Emergency Information:

Emergency Contact, other than parents (name, phone number and relationship to family):
1: ____
2: ____

Name and phone number of any specialist(s) your child sees on a regular basis:

____

____

Insurance Used for Patient:

Primary Insurance: ____

Policy Holder's **Last** Name: _____________________________

First Name & Middle Initial: _____________________________

Policy Holder's Birth Date: ______________

Group # _____________________ ID# _____________________

Secondary Insurance: ____

Policy Holder's Last Name: _____________________________

First Name & Middle Initial: _____________________________

Policy Holder's Birth Date: _______________

Group # _____________________ ID # _____________________

Billing statements sent to (If different from above):

Name ____

Relationship to patient ____________________

Resides with patient ___ yes ___ no

Address: ____

Phone: ________________________ Cell: _________________________

Privacy Constraints (Check One):

____ No restrictions. Okay to leave message/send mail.
____ Restrictions – Person to person with patient/guardian only.
____ Restrictions (specify):
____

In what language(s) are you most comfortable communicating?

____

Parent that we send notifications to:_____________________________________

We will email or text reminders to schedule appointments, reminders of scheduled appointments, and general notices from the practice. If you **DO NOT** use email or text, how would you prefer to be contacted regarding those issues? (check only one)

___Call cell phone ___Call home phone ___Call work phone

How do you prefer to be contacted about medical issues and billing issues?
___CallHome phone ___Call Cell phone ___Call Work phone

Where do you prefer billing statements to be sent?
___Mailing address ___Patient portal (requires registration on the portal)

Authorization for someone other than parents to bring child for care:
If parents are divorced or separated please fill out this section:
Who has custody? ___ joint custody ___mother ___father

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ___ yes ___ no

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

____

Consent to Treat

Written Acknowledgement of Receipt of Central Valley Pediatrics Notice of Privacy Practices
I, (Patient/Parent/Guardian), acknowledge receiving Central Valley Pediatrics Notice of Privacy Practices (The Notice). The Notice explains how CVP may use and disclose your protected health information for treatment, payment, and healthcare operations purposes. "Protected health information" means your personal health information found in your medical and billing records. If you have questions about the Notice, Please contact the Office Manager at (559) 431-6600.
General Consent to to treat
I, (Patient/Parent/Guardian), confirm that I am the parent/guardian of the Patient. I have the legal right to consent to medical and surgical treatment for this patient.
I, (Patient/Parent/Guardian), voluntarily authorize and consent to the medical care, treatment and diagnostic tests that Dr. Miranda and his designated associates or assistants believe are necessary for this child.
I, (Patient/Parent/Guardian), understand that by signing this form, I am giving permission to the doctors, nurses, physicians assistants, nurse practitioners and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.
Consent to Release and Obtain Information
I, (Patient/Parent/Guardian), in agreement with federal and state law, I agree to allow Central Valley Pediatrics to deliver the necessary care to this child in order to provide continuity of care and treatment. Central Valley Pediatrics and/ or the patient's provider may obtain from any source and examine and use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnosis, treatments and psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. I may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.
I, (Patient/Parent/Guardian), 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.
Electronic Prescriptions (IE-Prescribing)
I, (Patient/Parent/Guardian), voluntarily authorize Central Valley Pediatrics to allow E-Prescribing for the patients's mail order prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office, or until I withdraw my consent.
(If applicable) For Medi-cal patients only
I, (Patient/Parent/Guardian), give Central Valley Pediatrics consent to treat my child under the Children's Health and Disability Program. This consent allows CVP to disclose information to any organization associated with CHDP related to the care of my child.

Name: ____

Relationship: _____________________________ Signature ____

Date ____________________________________

Central Valley Pediatrics Financial Agreement

Authorization to pay benefits to physician: I hereby authorize payment directly to the physician the surgical and/or medical benefits, if any, for services rendered, realizing that I am responsible for paying any co-payments, deductibles and other fees not covered by my insurance carrier at the time of my child's visit.

Please provide us with current insurance card, Identification and best phone number and email address at time of your appointment. This assures that we can accurately bill your insurance and contact you directly regarding referrals, refill notifications, laboratory and x-ray results and appointment reminders. Failure to do so may cause delays.

Notice: There will be a charge of **$20** for any checks not honored by the bank, If your account is referred to a collection service, you will be responsible for the legal fees.

Authorization to release information: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.
Authorization to release information: I hereby authorize Central Valley Pediatrics to send immunization records, medication records and/or routine physical forms to my child's school or other physicians. CHDP patients authorize all information to be shared with that program.

Forms that require the attention of the provider and letters written on your child's behalf require a **$10** fee.

☐ **No Show Fee:** I understand that a **$20 fee** will be charged for appointments **($35 for well visits)** missed without 24 hours notice to Central Valley Pediatrics. This fee will not be charged if you contact us to cancel or reschedule an appointment. This fee will be applied to your account. You will be asked to pay this fee at the next appointment

☐ ______Initial

Student Status

_____Full Time Student ____Part Time Student/ Not Employed

Signature: ____ Date:______________