Patient Registration **PEDIATRIC ASSOCIATES OF KERSHAW COUNTY, PA**

PATIENT

PATIENT INFORMATION

Name _____
First Middle Last

Date of Birth _____ SS# _____ Sex: ❑ M ❑ F

Home Address _____

City _____ State _____ Zip _____

If child is 16 or older, patient cell phone number _____

INSURANCE

INSURANCE AND POLICY HOLDER INFORMATION

(We must have a copy of insurance card(s) in order to file insurance for you)

Insurance Co. Name _____ Insured's Name _____

Policy Number _____ Insured's Birth Date _____

Group Number (if applicable): _____ SS# _____

Patient's Relationship to Insured: Child / Self / Other _____
(Circle One)

Employer's Name _____ Effective Start Date of Insurance _____

FIRST PARENT

FIRST PARENT/GUARDIAN _____ Date of Birth _____

Mobile Phone ( ) _____ Work Phone ( ) _____

Home Phone ( ) _____ Social Security No. _____

Home Address *(if different from child)* _____

City _____ State _____ Zip _____

Employer _____

SECOND PARENT

SECOND PARENT/GUARDIAN _____ Date of Birth _____

Mobile Phone ( ) _____ Work Phone ( ) _____

Home Phone ( ) _____ Social Security No. _____

Home Address *(if different from child)* _____

City _____ State _____ Zip _____

Employer _____

We are required to collect the following information for each patient.

Please complete this section before returning the form.

Thank you.

Your preferred language
- ❑ English
- ❑ Spanish
- ❑ Other _____
- ❑ Decline to answer

Ethnicity
- ❑ Hispanic/Latino
- ❑ Non Hispanic
- ❑ Unknown/Refused

Your child's race
- ❑ American Indian/Native Alaskan
- ❑ Asian
- ❑ Pacific Islander/Hawaiian
- ❑ Black or African American
- ❑ White
- ❑ Black and White
- ❑ Asian and White
- ❑ Black and Asian
- ❑ Unknown
- ❑ Decline to answer

IN CASE OF EMERGENCY

ALTERNATE CONTACT (relative or friend) _____

Alternate Contact Phone ( ) _____

Relationship to patient _____

FINANCIAL RESPONSIBILITY

The undersigned agrees to assume the financial responsibility for all medical services given. If collection becomes necessary, the undersigned will pay all cost including attorney's fees.

Payment of medical fees is the responsibility of the patient. Your insurance company accepts your premium and is responsible to you for reimbursement. We will furnish you with enough information and assistance to file claims, but we cannot be responsible for collecting your insurance payments. We will allow 45 days for your insurance company to pay assigned claims, after which time you will be held responsible for payment of your account.

_____ _____ _____
Signature *Name (print)* *Date*

#002

CONTINUED ON REVERSE

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Date of Birth:_____

Pediatric Associates of Kershaw County, P.A. is authorized to release protected health information about the above named patient to the entries named below. This will include all medical information including Appointment information, Lab results, and financial information and give the parties listed below consent to bring the child to the office for care.

Name:_____ Relation:_____Phone #:_____

Name:_____ Relation:_____Phone #:_____

Name:_____ Relation:_____Phone #:_____

Name:_____ Relation:_____Phone #:_____

I give consent to Pediatric Associates of Kershaw County, PA to leave phone messages on the following phone numbers:

Home #:_____ Work #:_____

Cell #:_____ Other: _____

Patient Portal:
SRSsoft Patient Portal is a secure online access to your child's clinical summary. In the future this will expand to allow for secure messaging to communicate with the practice.

❑ Yes, I would like to be set up on the patient portal
Email Address:_____

❑ No, I do not wish participate with the patient portal.

South Carolina State Registry:
All immunizations are reported to the SC State Registry as required by law (Regulation 61-120)

Pharmacy/Escribe:
I agree that Pediatric Associates of Kershaw County, PA may request and use my child's prescription medications history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. This will permit our office to send prescriptions to the pharmacy electronically.

PHARMACY:_____

Notification of Patient Privacy Policy: The Health Insurance Portability and Accountable Act (HIPAA) has mandated that all health care providers make available The Notice of Privacy Practices. This notice is posted in our waiting room for your review and is available on our website: pedakc.com. Upon request a copy of The Privacy Notice will be made available to you. In signing below, you acknowledge and understand the above information.

Signature:_____Date:_____
Parent/Guardian