PEDIATRIC ASSOCIATES OF KERSHAW COUNTY, PA
Patient Registration

PATIENT

Child's Name: _____ **Gender(Please Mark One):** ___ M ___ F
(First) (Middle) (Last)

Date of Birth: _____ **SS#:** _____
(mm/dd/yyyy)

Home Address: _____
(Street) (City) (State) (Zip)

If child is 17 or older, patient cell phone number: _____

PARENT/GUARDIAN INFO

Mother/Guardian's Name: _____ **DOB:** _____ **SSN:** _____

Occupation: _____ Employer: _____

Home#: _____ **Cell#:** _____ **Alternate#:** _____

Home Address(if different from child): _____

City: _____ **State:** _____ **Zip:** _____

Father/Guardian's Name: _____ **DOB:** _____ **SSN:** _____

Occupation: _____ Employer: _____

Home#: _____ **Cell#:** _____ **Alternate#:** _____

Home Address(if different from child): _____

City: _____ **State:** _____ **Zip:** _____

INSURANCE

Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Patient's Relationship to Insured: Child / Self / Other: _____

Employer's Name: _____ Effective Date of Insurance: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Patient's Relationship to Insured: Child / Self / Other: _____

Employer's Name: _____ Effective Date of Insurance: _____

Emergency Contact

Name: _____ Phone Number: _____

Relationship to Patient: _____

FINANCIAL RESPONSIBILITY

(PLEASE READ AND SIGN BELOW)
I AUTHORIZE Pediatric Assoc. to render medical care to my child
I AUTHORIZE Pediatric Assoc. to file my health insurance and ASSIGN any benefits payable to Ped Assoc.
I UNDERSTAND AND ACKNOWLEDGE that I am ultimately responsible for any fees incurred for services provided to my child (regardless of insurance status).
Patient responsibility amounts are due in full at the time services are provided. This may include but is not limited to co-payments, co-insurance or account balances.
I UNDERSTAND AND ACKNOWLEDGE that if I do not have insurance I am responsible for any fees incurred for services rendered. I AGREE and ACKNOWLEDGE that it is my responsibility to notify Ped. Assoc immediately of any changes in my insurance.
Print Full Name: _____

Signature: _____ Relationship: _____ Date: _____

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 #: _____

Pharmacy Info

Pharmacy/Escribe:

I agree that Pediatric Associates of Kershaw County, P.A. 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: _____

Portal Info

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. ❑ No, I do not wish to participate with the Patient Portal.

Email Address: _____
Please Print Legibly

Preferred Contact Method:

Phone: _____ E-Mail: _____ Text: _____

Other Children

Siblings Names & Dates of Birth: **1.)** _____ DOB: _____

2.) _____ DOB: _____ **3.)** _____ DOB: _____

4.) _____ DOB: _____ **5.)** _____ DOB: _____

The Federal Government requires all medical practices to collect the following information from patients.
There is a provision in the law that allows patients to not answer these questions.
Please answer the following three questions or select the "I decline to provide this information" answer.

Child's Ethnicity is: (Please Select One)

A. Hispanic or Latino
B. Not Hispanic or Latino

Child's Race is: (Please Select One)

A. American Indian/Alaskan Native
B. Asian
C. Black or African American
D. Native Hawaiian or Pacific Islander
E. White/Caucasian
F. Other

Child's Preferred Language is: (Please Select One)

A. English
B. Spanish
C. Other:

❑ I decline to provide this information.

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