PATIENT REGISTRATION FORM

Please complete **ALL** fields with current information or mark N/A

Authorization

I/we have the legal right to preauthorize Covenant Pediatrics to deliver medical treatment to my/our child(ren). I/we request and authorize Covenant Pediatrics and its personnel to deliver medical care to my (our) child listed below.

Patient's Legal Name: _____ **Date of Birth (Mo/Day/Year)**_____ **Sex (circle) M F**

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

I prefer getting appointment reminders via: (please circle) TEXT* PHONE* EMAIL

Phone/Text:_____ **Email**_____

FAMILY INFORMATION (circle)

Patient lives with: Mom Dad Both Other (Please Specify)_____

Mom/Legal Guardian: _____ **Dad/Legal Guardian:** _____

DOB: _____**SSN:**_____ **DOB:** _____**SSN:**_____

Address (if different):_____ **Address (if different):**_____

_____ _____

Hm Phone: (____)_____ **Hm Phone: (____)**_____

Work: (____)_____ **Cell: (____)**_____ **Work: (____)**_____ **Cell: (____)**_____

Email: _____ **Email:** _____

Parent's Marital Status (Circle): Married Widowed Divorced Single Legally Separated Other

Siblings

_____**DOB**_____ _____**DOB**_____

_____**DOB**_____ _____**DOB**_____

Emergency Contact:_____ **Phone:** _____ **Relationship:**_____

PLEASE TELL US HOW YOU HEARD ABOUT COVENANT PEDIATRICS_____

*****PLEASE READ ALL INFORMATION CAREFULLY*****

Preauthorization to Treat Minors and Permission to Discuss Protected Health Information

If I/we cannot be present with my child, I/we give permission for the persons listed below to authorize medical treatment for my child. I/we understand that protect health information may be shared with the authorized individual to assist them in decision making.

Limitations

Identify any limitations on the medical services that may be given or the time frame for which this authorization is given. If none, write "none."

_____

_____

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

PRIVACY PRACTICES AND INDIVIDUAL RIGHTS ACKNOWLEDGMENT

I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices and Individual Rights (Summary version) and had the opportunity to obtain a copy of the Privacy Practice and Individual Rights (Full version). I understand that acknowledgment to be in force for all children for whom I am the caregiver whether by adoption, birth, or guardianship.

I AGREE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Print Name:_____Signature:_____

Date:_____ Relationship to above patient:_____