Black Hills Pediatrics L.L.P.

PATIENT REGISTRATION

Today's Date: ______________________

PATIENT INFORMATION

Child's First Name: ____________________ Middle Name: ______________ Last Name: __________________________

Date of Birth: ______________________ SS#: ____________________ Female [ ] Male [ ]

Address: ____

City: ____________________________________ State: __________________ Zip: ______________

Person Responsible for Account: ____ **Phone:** (   )____________

Mailing Address: ____ **Relationship to patient:** ______________

Mother's Name: ______________________________________ DOB: ____________ SS#: ____________________

Address (if different than child): ____ Phone: (   )__________

Mother's Employer: ____________________________________ Work Phone: (   )____________________

Father's Name: ______________________________________ DOB: ____________ SS#: ____________________

Address (if different than child): ____ Phone: (   )__________

Father's Employer: ____________________________________ Work Phone: (   )____________________

Are Mother and Father: Married [ ] Divorced [ ] Separated [ ] Other [ ]

If Foster Parent, Your Name: ____

Address: ____ Phone: (   )__________

Caseworker name, county and telephone #: ____

INSURANCE INFORMATION

Primary Insurance: ____________________________ ID #: __________________________ Group #: ______________

Insurance Company Address: ____ Effective Date: ______________

Policy Holder's Name:__________________________ DOB: ____________ Relationship to Patient: ______________

Secondary Insurance: __________________________ ID #: __________________________ Group #: ______________

Insurance Company Address: ____ Effective Date: ______________

Policy Holder's Name:__________________________ DOB: ____________ Relationship to Patient: ______________

Relative or Person (not in your household) to notify in case of Emergency: ______________________________

Address: ____ Phone: (   )__________

PAYMENT DUE AT TIME OF SERVICE: CASH, CHECK, OR CREDIT CARD UNLESS OTHER ARRANGEMENTS ARE MADE!

I have read the above and understand the payment policy. Signed ______________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize the release of any medical information necessary to process insurance claims. I also authorize payment directly to the above-named physician of benefits payable under my policy, which I understand will be credited to my account. I will be financially responsible to the physician for any charges that are co-pay, deductible, or not paid by insurance.

Signed ________________________________

Guardian/Policy Holder

******* It is the responsibility of the guarantor/guardian to determine if the physicians of Black Hills Pediatrics, L.L.P. Physician Assistants, or any outreach physicians, are providers in your insurance network. It is not possible for the clinic to check thousands of individual policies.**

PLEASE CONTINUE ON REVERSE

Revised 01/2015

Compliance with meaningful use standards required by the government will result in improved health outcomes for specific patient populations.

Race:

☐ American Indian or Alaska Native ☐ Caucasian

☐ Black or African American ☐ Hispanic

☐ Native Hawaiian ☐ Other Pacific Islander

☐ Asian ☐ Declined to Report

Ethnicity:

☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Declined to Report

Language:

☐ English ☐ Native American ☐ Spanish ☐ Other

Authorization to view patient prescription history from external sources: ☐ Accept ☐ Decline

Black Hills Pediatrics and Neonatology, LLP is continuing our efforts to make sure that we have the appropriate information to contact you about your child's care.

Name of Person Completing Form: ______________________ Relationship: ____________________

List all children in household:

1.______________________________________ Date of Birth: _________________________

2.______________________________________ Date of Birth: _________________________

3.______________________________________ Date of Birth: _________________________

4.______________________________________ Date of Birth: _________________________

5.______________________________________ Date of Birth: _________________________

Preferred Phone #: ________________________

Enable Phone Call and/or Text Call ☐ Text ☐

Preferred time to call: Morning ☐ Afternoon ☐ Evening ☐

Preferred Language: English ☐ Spanish ☐

Please review the types of reminders that we can use and whether you wish us to do so if the need arises.

Appointment Reminders Yes ☐ No ☐ Lab Results Yes ☐ No ☐

Health Maintenance Yes ☐ No ☐ Rx Confirmation Yes ☐ No ☐

General Notification Yes ☐ No ☐

Do you wish us to enable email for communication? Yes ☐ No* ☐

If yes, please provide your email address: ____

*If no, this means you will no longer be able to access your child's record through the online web portal.