Estrella Pediatrics P.C. Patient Registration

Patient Last name	First:	MI	DOB:	M/F
____________________	____________________	_____	__________	________
____________________	____________________	_____	__________	________
____________________	____________________	_____	__________	________
____________________	____________________	_____	__________	________

Patient's Home Address: ____
Street Apt# City State Zip

Patient Lives With: ( ) Mother ( ) Father ( ) Both ( ) Other, please specify______________________

Please Circle (Natural, Step-parent, Adoptive Parent, Guardian**)**

Mother's name______________________ **SS#**_______-______-_________ **DOB**: ___________

Home Address

____

Street Apt# City ST Zip

Phone: Primary (____)______-________ Alternate (______)______-_________ Work (____) _____-__________

Circle Type: Home or Cell Circle Type: Home or Cell

Employer: **Occupation:**

Marital Status of child's parents (Please Check One): Married _____ Single _____ Separated _____ Divorced _____

Please Circle (Natural, Step-parent, Adoptive Parent, Guardian**)**

Father's name______________________ **SS#**_______-______-_________ **DOB**: ___________

Home Address

____

Street Apt# City ST Zip

Phone: Primary (____)______-________ Alternate (______)______-__________ Work (____) _____-__________

Circle Type: Home or Cell Circle Type: Home or Cell

Employer: **Occupation:**

In Case of Emergency: Name _____________________ **Relationship:** _______________ **Primary Phone:** _____________

INSURANCE INFORMATION	Although we scan your insurance card not all the information necessary is on the card.	Please complete all the information requested.	If the information is incomplete, the account will be self-pay.	
Primary Insurance Company Name	Name of Policy Holder	Policy Holder DOB	Policy/ID Number	Group Number
Secondary Insurance Company Name	Name of Policy Holder	Policy Holder DOB	Policy/ID Number	Group Number

Race	Ethnicity	Language
Email Address	Text SMS OK: Yes or No	How did you hear about our practice?

I consent for medical treatment for the patient(s) listed above and hereby authorize payment directly from my insurance company to the undersigned physicians of Estrella Pediatrics. I understand that payment in full of my responsible portion is required at the time of visit. I am financially responsible for any balance due. I authorize the release of any medical information necessary to carry out treatment, payment and health care operations of my child. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney's fees, and associated costs.

Financial/Office Policy & HIPPA ACKNOWLEDGEMENT:

I have read, understood, and have had the opportunity to ask questions of the foregoing office and financial policy and agree to abide by the terms of this policy. I also acknowledge that a copy of the Notice of Privacy Practices, including Omnibus Rule, has been made available to me. I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE),

✍ ______________________________________ _______________ _______________

Parent/Guardian Signature **Relationship** **Date**

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