DESERT WILLOW PEDIATRICS ________ FAMILY REGISTRATION FORM

CHILDREN'S INFORMATION – PLEASE LIST ALL CHILDREN TO BE REGISTERED

CHILD'S LEGAL NAME	DOB	Sex	Ethnicity & Race
CHILD'S LEGAL NAME: Last: ____________________ First: ___________________ Preferred Language: [ ] English [ ] Spanish [ ] Other: ____________________	DOB:	[ ] Male [ ] Female [ ] Other __________	Ethnicity & Race (Meaningful Use Data) [ ] Hispanic [ ] Non-Hispanic Race: _____________________________________
CHILD'S LEGAL NAME: Last: ___________________ First : ___________________ Preferred Language: [ ] English [ ] Spanish [ ] Other: ____________________	DOB:	[ ] Male [ ] Female [ ] Other __________	Ethnicity & Race (Meaningful Use Data) [ ] Hispanic [ ] Non-Hispanic Race: _____________________________________
CHILD'S LEGAL NAME: Last: ___________________ First : ___________________ Preferred Language: [ ] English [ ] Spanish [ ] Other: ____________________	DOB:	[ ] Male [ ] Female [ ] Other __________	Ethnicity & Race (Meaningful Use Data) [ ] Hispanic [ ] Non-Hispanic Race: _____________________________________
CHILD'S LEGAL NAME: Last: ___________________ First : ___________________ Preferred Language: [ ] English [ ] Spanish [ ] Other: ____________________	DOB:	[ ] Male [ ] Female [ ] Other __________	Ethnicity & Race (Meaningful Use Data) [ ] Hispanic [ ] Non-Hispanic Race: _____________________________________

PARENT/GUARDIAN INFORMATION

Parent/Guardian	Address	Contact
[ ] Father [ ] Mother [ ] Other : ___________________ Name: ____ DOB: ____	Address: __________________________________ __________________________________ ____________________________________	Primary Phone #: ___________ _________________________ [ ] Home [ ] Cell Email: _______________________ ______________________________
[ ] Father [ ] Mother [ ] Other : ___________________ Name: ____ DOB: ____	Address: __________________________________ __________________________________ ____________________________________	Primary Phone #: ___________ _________________________ [ ] Home [ ] Cell Email: _______________________ ______________________________

EMERGENCY CONTACTS

(List additional persons who may bring your children for appointments or who we are authorized to communicate with for medical information)

Name	Relation to Child	Phone
Name: ____________________________ ___________________________________	Relation to Child: __________________________________	Phone: ______________________________ ____________________________________
Name: ____________________________ ___________________________________	Relation to Child: __________________________________	Phone: ______________________________ ____________________________________
Name: ____________________________ ___________________________________	Relation to Child: __________________________________	Phone: ______________________________ ____________________________________

INSURANCE INFORMATION – PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance:	Policy ID#	Relation to Child:	Policy Holder DOB:
Insurance:	Policy ID#	Relation to Child	Policy Holder DOB:
PREFERRED PHARMACY:			

ASSIGNMENT OF INSURANCE BENEFITS/CONSENT TO TREAT/PRIVACY POLICY

- ✓ I understand that I am financially responsible for all professional charges that my children may incur
- ✓ All copayments, non-covered charges, and any account balances are due at the time of service. All costs not paid by insurance are due upon receipt of statement. NSF checks returned by your financial institution will incur a $35 fee assessed to the account.
- ✓ I hereby authorize payment of medical benefits direct to Desert Willow Pediatrics, PLLC. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.
- ✓ Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give permission to Desert Willow Pediatrics, PLLC to treat my child in their office as required by the events of that emergency situation.
- ✓ Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Privacy Practices for Desert Willow Pediatrics, PLLC.

_________________________________ ______________________________________ ________________________

Signature (Patient/Parent/Guardian) Printed Name Date