5333 W. University Drive McKinney, TX 75071 972 569-9904 phone 972 569-9943 fax
ABCPediatrics-McKinney.com

Patient Registration

Child 1: Last Name: _____ First Name: _____ MI: _____
Nickname: _____
Date of Birth: _____/_____/_____ Sex: _____ Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown / May decline Race: Asian / Black / Hawaiian / White / May decline

Child 2: Last Name: _____ First Name: _____ MI: _____
Nickname: _____
Date of Birth: _____/_____/_____ Sex: _____ Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown / May decline Race: Asian / Black / Hawaiian / White / May decline

Child 3: Last Name: _____ First Name: _____ MI: _____
Nickname: _____
Date of Birth _____/_____/_____ Sex: _____ Primary Language: _____
Ethnicity: Hispanic / Non-Hispanic / Unknown / May decline Race: Asian / Black / Hawaiian / White / May decline

Mailing Address:

_____
(Street or PO Box) (City) (State & Zip)
Home Phone: (_____) _____ - _____

Insurance:
Primary Policy: Policy Holder's Name: _____
Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female
Insurance Carrier: _____ Patient's Relation to Policy Holder: _____
ID#: _____ Group #:_____

Contact 1: Name: _____ Relation to Patient: _____
Lives with patient? Yes / No
Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____
Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____
Email: _____
Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding (circle one):
Medical Issues (Where the doctor or nurse should contact you): Home Phone / Work Phone / Cell Phone
Appointment Reminders: Home Phone / Work Phone / Cell Phone
Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone /Email
General Practice Notices: Home Address / Home Phone / Cell Phone
Patient Notifications via website (Once available): Cell Phone / Email

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Contact 2: Name: _____ Relation to Patient: _____
Lives with patient? Yes / No
Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____
Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Email: _____
Employer: _____ Occupation: _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here:

_____

Additional Person(s) (Other than parent or guardian) allowed accompanying child or receive medical information:

_____

Person(s) not allowed to receive medical information: _____

Additional Contact Questions:
Who should receive billing statements? _____
May all contacts have access to the patient's records electronically (Once available)? Yes / No /

_____

If parents are divorced or separated please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contact, other than parents: Name & Relationship
1: _____ Phone: (_____) _____ - _____

How did you hear about us (if new patient)**:** _____

I/We Agree to:

1. Give the doctors and staff permission to examine and treat my child.
2. Authorize release of information to my insurance carrier for the purpose of processing claims. I hereby assign medical insurance benefits, to include major medical to the doctors at ABC Pediatrics. Pay for services when rendered unless other arrangements are made prior to the visit.
3. Should my account become delinquent, I agree to pay the necessary collection and/or attorney's fee.
4. Use the after-hours call service only for urgent purposes. I realize that if used for other than urgent purposes after normal business hours, I may be assessed a $10 fee.
5. Be financially responsible for all charges deemed to be "non-covered benefits" by my insurance company even if the insurance's Explanation of Benefits state the procedure is a "non-covered benefit" and "patient is not responsible."
6. Keep appointments in a timely manner. If not, I realize that there is a $30 fee if I am 20 or more minutes late.

This assignment will remain in effect until revoked by me in writing.

Signature: _____ Date: _____