PATIENT REGISTRATION
House Calls 4 Kids LLC

Patient Information

Patient_____ Sex: ☐ M ☐ F DOB____/____/_____

Mother/Guardian_____ DOB____/____/_____ SS#_____

Address_____ Home Phone_____

City/State/Zip_____ Occupation_____

Employer_____ Work Phone_____

Father/Guardian_____ DOB____/____/_____ SS#_____

Address_____ Home Phone_____

City/State/Zip_____ Occupation_____

Employer_____ Work Phone_____

Sibling_____ Sex: ☐ M ☐ F DOB____/____/_____

Sibling_____ Sex: ☐ M ☐ F DOB____/____/_____

Sibling_____ Sex: ☐ M ☐ F DOB____/____/_____

Sibling_____ Sex: ☐ M ☐ F DOB____/____/_____

Children live with: ☐ Father ☐ Mother ☐ Guardian_____ ☐Other_____

Emergency Contact Person_____ Relationship_____ Phone_____

Party Responsible for Payment of Medical Services: ☐ Father ☐ Mother ☐ Guardian ☐ Both_____

How did you hear about House Calls 4 Kids?_____

Insurance Information

Primary_____ Claims Address_____

Policy #_____ Group #_____ Co-payment $_____

Secondary_____ Claims Address_____

Policy #_____ Group #_____ Co-payment $_____

Name of Insured_____ DOB____/____/_____ Relationship_____

Medicaid/Denali Kid Care_____ Current Card #_____

Tricare Sponsor_____ SS#_____

Authorization of Treatment and Assignment of Benefit

I authorize Margaret "Peggi" Kahler, ANP to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to House Calls 4 Kids for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: _____

_____

Parent/Guardian's signature_____ Date_____

Witness" signature_____ Date_____

HIPPA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.

HIPPA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.
Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care concerns.

  Name _____
  Phone _____
  Name _____
  Phone _____

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

  Name _____
  Phone _____
  Name _____
  Phone _____

- Please print the address of where you would like your billing statements and/or correspondence from this office to be sent if other than you home address.

  _____
  _____
  _____

- Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home telephone number.

  _____
  _____
  _____
  _____

Please be aware that a cell phone is not a secure and private number!

- Can confidential messages (i.e., appointments reminders, etc.) be left on your telephone answering machine or e-mail? ☐ Yes ☐ No

- If you have a primary clinic or MD that your child regularly visits, do I have permission to send or fax a copy of each visit to them? ☐ Yes ☐ No

_____
PATIENT NAME print

_____ Date_____
PARENT/GUARDIAN SIGNATURE

Notes

_____

_____

_____

_____

5/29/07