Phone: 215-638-0555
Fax: 215-638-2929
Website: www.tpeds.com

PATIENT REGISTRATION FORM Today's Date: _____

Last Name of Child	First Name of Child	Date of Birth

Race: ( ) White ( ) Black ( ) Asian ( ) American Indian/Alaskan Native ( ) Other:_____

Ethnicity: ( ) Non-Hispanic or Latino ( ) Hispanic or Latino

Primary Language Spoken: ( ) English ( ) Spanish ( ) Chinese ( ) Farsi ( ) Russian ( ) Vietnamese Other:

Can you speak/understand English? Y N

Email Address: _____

Address: _____

Parent or Guardian Name: _____

Home Phone Number: _____ Can we leave a message on your tape? [ ] Yes [ ] No

Cell Phone Number: _____ Can we call you on your cell phone? [ ] Yes [ ] No
Whose cell phone is this?_____ Can we leave a message on your cell? [ ] Yes [ ] No

Work Phone Number: _____ Can we call you at work? [ ] Yes [ ] No
Who will we be calling?_____ Can we leave a message at work? [ ] Yes [ ] No

Do we have your permission to use an automated telephone system to confirm appointments? [ ] Yes [ ] No

[ ] I AGREE TO REMOVE CALLER BLOCKING WHEN EXPECTING DOCTOR TO CALL

Emergency Contact Person (not in same household)
Name: _____ Phone Number: _____

Release and Assignment

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, Blue Shield, HMO Plans, and Commercial Insurance to Torresdale Pediatrics. I understand that I am financially responsible for all charges whether or not covered by insurance. I hereby authorize and designee to release any information to secure payment on my child's behalf

Signature: _____ Date: _____

Printed Name: _____

BILLING INFORMATION

Mothers Name: _____ DOB:_____

Address: ( ) same as on front page

_____

City_____State_____ Zip Code: _____

Employer: _____ Work Telephone #: _____

Employer Address: _____

Marital Status: _____ Cell Phone #:_____

Fathers Name: _____ DOB:_____

Address: ( ) same as above

_____

City_____State_____ Zip Code: _____

Employer: _____ Work Telephone #: _____

Employer Address: _____

Marital Status: _____ Cell Phone #:_____

INSURANCE INFORMATION

Name of Primary Insurance: _____

Address: Phone:

Identification Number: _____ Group #: _____

Name that this Insurance is Under: _____ Their DOB:_____Copayment:_____

Do you have a second insurance? ( ) Yes ( ) No

Name of Second Insurance: _____

Address: Phone:

Identification Number: _____ Group #: _____

Name that this Insurance is Under: _____ Their DOB:_____Copayment:_____

PHARMACY

What is the name of the pharmacy you use? _____

Address:_____ Phone Number: _____

FINANCIAL RESPONSIBILITY: I understand that payment of all medical care is due and payable at the time of service. With dependents of divorced parents, responsibility and payments shall be that of the guardian bringing the child for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient's accounts in case of default, including reasonable attorney fees and court costs. I hereby grant permission to Torresdale Pediatrics to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Torresdale Pediatrics. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signature: _____ Print Name: _____ Date: _____

HIPAA Privacy Practices Acknowledgement Form

I have been provided with a copy of the Notice of Privacy Practices for Torresdale Pediatrics to review and by my signature below acknowledge that I have reviewed it.

Patient name(s): _____

Name of person reviewing the information (if someone other than patient)

_____ Relationship to patient: _____

Signature: _____ _____

Patient or Patient Representative *Date*

Disclosure of My Personal Health Information

I request the following allowance for the disclosure of my child(ren)'s health information:
(In addition to patient/patient representative please list any person(s) with which we may disclose/discuss patient information)

Name of Individual	Relationship to Patient (parent, sibling, relative, friend etc)

Authorization for Consent to Treat a Minor

I, _____, hereby authorize

Name of parent or legal guardian

_____ to bring my child (ren) _____

Name of person authorized to bring child to appointment *Name of Child(ren)*

to his/her appointments at Torresdale Pediatrics. The authorization shall be limited to the following time period: _____. If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

Signature _____ Date _____