THE Pediatric PLACE

Registration Form

Date:	Primary: □ Dr. Barrient □ Dr. Busenlener □ Dr. Philippe	
PATIENT INFORMATION		
Name:	DOB:	□ Male □ Female
Preferred Name:	Race:	□ Hispanic □ Non-Hispanic
School/Daycare Attending:		Grade:
Previous PCP:		
Sibling 1:	DOB:	□ Male □ Female
Sibling 2:	DOB:	□ Male □ Female
Sibling 3:	DOB:	□ Male □ Female
Sibling 4:	DOB:	□ Male □ Female
Sibling 5:	DOB:	□ Male □ Female
FAMILY/CONTACT INFORMATION		
Parent 1:	DOB:	Mobile:
Address:		Email:
Parent 2:	DOB:	Mobile:
Address:		Email:
Patient resides primarily with: □ Both Parents □ Mother □ Father □ Other:		
Are there any legal restrictions in place disallowing a non-custodial parent/other from consenting to medical treatment or obtaining information regarding medical treatment for this patient? □ Yes □ No If yes, please explain below and provide all supporting documentation.		
EMERGENCY CONTACT		
Name:		Mobile:
Relationship to Patient:		
Name:		Mobile:
Relationship to Patient:		

Registration Form

INSURANCE INFORMATION		
Patient is not covered by insurance (Self-pay):	□ Yes	□ No
Primary Insurance:		
Subscriber:	DOB:	SSN:
Address (if different than page 1):		
Mobile:	Patient's Relationship to Subscriber:	
Employer:	Employer Phone:	
Secondary Insurance:		
Subscriber:	DOB:	SSN:
Address (if different than page 1):		
Mobile:	Patient's Relationship to Subscriber:	
Employer:	Employer Phone:	

PHARMACY INFORMATION
Preferred Pharmacy:

HOW DID YOU FIND US?

NOTICE OF PRIVACY PRACTICES
A notice of our Privacy Practices will be included but can also be found online at https://thepedplace.com.

GUARANTOR
If the patient's parents / legal guardians are unmarried or legally separated, the parent or guardian accompanying the child to the first appointment will be established as the account guarantor. In order to change the guarantor on the account, a Change of Guarantor Request form must be completed. The patient or the adult accompanying the patient to the appointment is responsible for presenting an updated insurance card at each visit.

AUTHORIZATION & RELEASE	
I authorize The Pediatric Place, LLC to release any medical or other information necessary to process medical claims for services provided. I request payment of government benefits to The Pediatric Place, LLC. I authorize payment of medical benefits to The Pediatric Place, LLC for services provided. I understand that I am personally responsible for payment of services provided and ensuring that the patient is added to the insurance policy in a timely manner and that all insurance information is kept up to date.	
Printed Name:	Date:
Signature:	Relation to Patient: