Date_____

Pediatric Patient Registration

Name_____**Birth Date**_____
Last First M.I.
Preferred name_____**Social Security #**_____
Address_____
Phone_____**Email**_____

The Federal Government requires this information for electronic medical records:
Gender: Male____Female____Declined____
Ethnicity: Not Hispanic____Hispanic____Declined/Unknown____
Race: White____AfricanAmerican____American Indian or Alaska Native____Asian____
Native Hawaiian____Other_____Declined/unknown_____

Parents Information: Please complete for each parent

Married **Separated** **Divorced** **Never Married**

Name:_____**Birth Date:**_____
Last First M.I.
Relation to patient_____**Social Security #**_____
Address_____
Phone_____**Work phone**_____**Email**_____

Name:_____**Birth Date:**_____
Last First M.I.
Relation to patient_____**Social Security #**_____
Address_____
Phone_____**Work phone**_____**Email**_____

Emergency Contact Information: (Someone not listed above, knows how to reach you)

Name:_____
Last First M.I.
Relation to patient_____
Address_____
Phone_____**Work phone**_____

Signature_____**Date**_____

Authorization for Medical Information

My preferred contact: Phone_____ Other_____

I authorize information about my visits and account to be released to:
Parent 1_____ Phone_____
Parent 2_____ Phone_____
Spouse/Partner_____ Phone_____
Other_____ Phone_____

I authorize that lab/results may be left:
On voice-mail:_____ Other_____

Preferred Pharmacy_____ Phone_____

Guarantor (Person financially responsible for child)_____

Insurance Policy Holder (Please provide the insurance card for us to photocopy)

Name:_____ Birth Date:_____
Last First M.I.

Relation to patient_____ Social Security#_____
Address_____
Phone_____Work phone_____Email_____
Employer_____
Health Insurance Company_____

The patient (parent/guardian) is responsible for all fees, regardless of insurance coverage. This includes, but is not limited to, co-insurance, co-payment, deductible, and non-covered services.

I hereby authorize Cornerstone Family Physicians, P.C. to furnish insurance companies or their representative's information concerning my (my dependent's) illness and treatments. I hereby assign to Cornerstone Family Physicians, P.C. all payments for medical services rendered to myself (or dependent). I understand I am responsible for any amount not covered by insurance. I agree that should this account become delinquent, I am responsible for any attorney fees and costs of collection.

_____**Date**_____
Signature of patient (over 18 years of age), parent or guardian