Mother's Maiden Name _____

Pediatric Associates, LLP

CHILD REGISTRATION FORM

To be filled out by parent or guardian.

Date _____

Mother's First & Last Name _____ Father's First & Last Name _____

Birthdate _____ Birthdate _____

Soc. Security No. _____ Soc. Security No. _____

Address _____ Address _____

_____ _____

Cell Phone No. _____ Cell Phone No. _____

Home Phone No. (____) _____ Home Phone No. (____) _____

Employer _____ Employer _____

Work Phone No. (____) _____ Work Phone No. (____) _____

Parents Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Unmarried ☐ Widowed

CHILDREN:

Name	Birthdate	Sex	Child Lives With	Primary Care Physician

PRIMARY INSURANCE

Name of Company _____

Insurance Holder _____ Policy No. _____

SECONDARY INSURANCE

Name of Company _____

Insurance Holder _____ Policy No. _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Pediatric Associates to release any information acquired in the course of my child/children's examinations or treatments to my insurance company.

Parent/Guardian's Signature _____ Date _____

Person to Contact in case of emergency (other than parent)

Name _____

Address _____

_____

_____

Phone No. (____) _____

How did you hear about Pediatric Associates?

_____

_____

_____

_____

PEDIATRIC ASSOCIATES, LLP

Release of Information Authorization Form

I understand that my records may contain information regarding the diagnosis or treatment of sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric disease. I understand that in accordance with Federal and State laws, this release does not include permission to release information specifically related to HIV (AIDS) and if such information is to be requested, additional specific release forms are required. I authorize the disclosure of health information as described below.

PATIENT NAME_____ **BIRTHDATE**_____

Who is releasing information:
Pediatric Associates, 601 North Way, Camillus, NY 13031

Who would you like to receive the information (who, in your family, you authorize us to speak with. For example, step-parents, girl/boyfriends, babysitters, grandparents.) If a person, other than the legal parent/guardian, is not listed below, they will be unable to gain access to personal health information, either written or verbal.

Name of Person	Relationship to Patient
Name of Person	Relationship to Patient
Name of Person	Relationship to Patient
Name of Person	Relationship to Patient
Name of Person	Relationship to Patient

Reason for Disclosure:_____

Description of information that may be disclosed:_____

This authorization expires on the patients 18th birthday.

You may revoke or terminate this authorization by submitting a written revocation. You should contact the Privacy Officer to terminate this authorization.
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____

Signature of Patient or Representative **Date**

_____

Relationship of Patient Representative to Patient