Patient Registration Form

Please fill out the form below for each child in your family to the best of your ability. If you need assistance, please do not hesitate to ask a staff member.

Patient Full Name:_____ **Preferred Name/Nickname:**_____

Date of Birth: _____ **Sex Assigned at Birth:** M / F **Gender Identity:**_____ **Preferred Pronouns:**_____

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Declined to Specify
- ☐ Other Race: _____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other Ethnicity
- ☐ Declined to Specify

Primary Language: _____ **Do you need an interpreter?**_____

Primary Address: _____

Email & Cell Phone Number (if >14 yrs old):_____

PCP Choice:

- ☐ **Robyn M Hayes, cPNP**
- ☐ **JoséAlberto Betances, MD**

Parent/Guardian 1 Name: _____ **Relationship to patient:** _____

Date of Birth: _____ **Preferred Pronouns:** _____

Email Address: _____

Address (if different than child's): _____

Primary Phone:_____ (type: cell home work) **Alt Phone:**_____ (type: cell home work)

Parent/Guardian 2 Name: _____ **Relationship to patient:** _____

Date of Birth: _____ **Preferred Pronouns:** _____

Email Address: _____

Address (if different than child's): _____

Primary Phone:_____ (type: cell home work) **Alt Phone:**_____ (type: cell home work)

Primary Insurance Information:

Insurance Company Name: _____ **Name of Guarantor**: _____

Address: _____

SSN of Insured: _____ID #: _____ Group #: _____

Secondary Insurance Information:

Insurance Company Name: _____ **Name of Guarantor**:_____

Address: _____

SSN of Insured: _____ ID #: _____ Group #: _____

Emergency Contact Information:

Contact Name: _____ Relationship to Patient:_____

Cell Phone: _____ Home:_____

Preferred Pharmacy:

Name: _____ Address: _____

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, fees for in-office services and/or tests, and any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). I further understand that it is my responsibility to obtain any necessary referrals from primary care of other providers, as applicable.

Also, please be advised our office may contact you via an automated system through phone, email, or text message, regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I provide written notice to HD Pediatrics, PLLC of my intention to revoke this authorization.

I have fully read and understand the above statement of payment policy. I hereby assign to HD Pediatrics, PLLC any benefits paid on my behalf. I authorize HD Pediatrics, PLLC to release my health information to obtain reimbursement for the provision of health care services. I understand that HD Pediatrics, PLLC does not accept partial payments made by insurance carriers as full payment for the services rendered, and I will be responsible for any charges not covered by insurance.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for the purposes of patient identification. ☐ check here if you would like to opt of any photographs

Massachusetts Vaccine Registry (if applicable)

Please be advised that our office submits confidential data of children and adult vaccinations to the MIIS (Massachusetts Immunization Information System) per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of a patient's immunization history.

Signature Required: The undersigned acknowledges that I have read and understand the above terms and conditions.

_____ _____ _____

Parent/Guardian/Patient (if >18yrs) (PLEASE SIGN) Parent/ Guardian/Patient (if >18yrs) (PLEASE PRINT) Date