Milestones
PEDIATRIC AND ADOLESCENT CARE

PATIENT REGISTRATION FORM
Please print clearly and bring to your first appointment.

Patient Name: _____ Nickname: _____ Birthdate:_____ Sex: M / F

Demographic Information:	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefers not to answer Preferred Language: _____ ☐ Prefers not to answer	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefers not to answer

SIBLINGS

Other Children's Names	Nickname	Birthdate	Sex	Demographics (same as above?)	If different, please specify:
1.			**M F**	**Y/N**	
2.			**M F**	**Y/N**	
3.			**M F**	**Y/N**	
4.			**M F**	**Y/N**	
5.			**M F**	**Y/N**	

ACCOUNT INFORMATION

Custodian (patient lives with):	**Guarantor (bills sent to):**
Name: _____	Name: _____
DOB: _____	DOB: _____
Address: _____	Address: _____
_____	_____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Email: _____	Email: _____

Appointment Reminders (circle one): Phone / Email / Text (**if you want texts, talk to the front desk to opt-in**)

List phone # or emailfor reminders: _____

Mother's Maiden Name:_____

Emergency Contact: (Name & Relation): _____Phone#:_____

Would you like to sign up for My Kid's Chart, our patient portal, so you can securely view and print your child's medical record? We will e-mail you the link so you can sign up. [ ] Yes [ ] No

If yes, please provide e-mail:_____

Pharmacy Name: _____ Pharmacy Phone #: _____

How did you hear about our practice? [ ] Friend/Family [ ] Referral [ ] Facebook [ ] Advertisement [ ] Other_____

INSURANCE INFORMATION

Primary Insurance holder's name: _____

Policy holder's Date of Birth: _____/_____/_____

Insurance holder's address: (if different from above) _____

Primary Insurance Policy: _____ Is this an HMO / POS plan? [ ] Yes
Is this a Medicaid Plan? [ ] Yes

Insurance Policy # _____ Group _____

Insurance Address_____ Phone#:_____

Any Secondary Insurance? If yes, Plan & Policy #:_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this physician/clinic to release any information required in the course of my examination or treatment. I further expressly agree & acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each & every claim to be submitted for myself and/or dependents.

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for medical benefits, in any otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

Signature _____ Date _____

NOTICES OF PRIVACY PRACTICES (HIPAA): The U.S. Department of Health & Human Services has developed a Notices of Privacy Practices for health care providers to communicate with their patients entitled, "Your Information. Your Rights. Our Responsibilities". This notice describes how medical information about you may be used and disclosed and how you can get access to this information. I hereby understand that this policy can be viewed on our website at: http:// www.milestoneskids.com/forms---policies-1.html and that our staff would also be happy to provide you with a copy of this notice if needed.

Signature _____ Date _____

If there is an individual other than parent or legal guardian authorized to receive your child's health information, please indicate below:

Name _____ Relationship _____

Signature _____ Date _____