



## Patient Registration

### Tell us about the patient

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Nickname: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender:       Male     Female

### Tell us about the family

Parent/Guardian Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Work): \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Parent/Guardian Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Work): \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Siblings:  
Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Who should we call in case of emergency?

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Work): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Will insurance be used for today's visit?

- No. The visit will be paid for today.
- Yes. Please provide the receptionist with your insurance card. If you are covered by multiple insurance companies, indicate which is primary, secondary, etc.

Acorn Pediatrics accepts most major insurance plans. Check with the receptionist for more information.

Privacy Policy (Please mark all that apply)

- I acknowledge that I have received the Acorn Pediatrics Notice of Privacy Policy.
- I authorize Acorn Pediatrics to contact me regarding my child's appointment, health information, lab results, billing problems or any other situation relating to my child's healthcare.  
I prefer to be contacted at the following phone number: Home Cell Work
- I authorize Acorn Pediatrics to leave a detailed message regarding my child's healthcare. Mark all that apply:  
Voicemail With the following individual(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Authorization to Treat in Absence of Parent or Guardian (optional)

- I authorize my child to be brought to Acorn Pediatrics by \_\_\_\_\_. I consent for my child to be treated, and I agree to be responsible for the cost of such care.

Agreement to Pay

I authorize the release of my child's medical records to my health plan, insurance company, or Medicaid, as applicable, for payment. **I request that my health plan, insurance company, or Medicaid, as applicable, make payment for services I receive at Acorn Pediatrics directly to Acorn Pediatrics, LLC.** I understand that I am responsible for payment for any services that are not covered by any health plan, insurance company, or Medicaid, including co-payments and deductibles. I understand **co-payments are due prior to my child being seen.** I understand that if my child does not have health insurance, or if I do not mark this circle, I will be responsible for payment which is due at the end of each visit. For any balance that remains unpaid 60 days after the date of service, I agree to pay 1.5% monthly interest charges (18% APR). Should any balance be referred to a collection agency, I agree to pay an additional fee.

By signing below, I am confirming that I understand and consent to the assignment of benefits, payment responsibility, treatment(s), and disclosures above.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to patient: Parent Guardian Other: \_\_\_\_\_

**Thank you for choosing our practice for the care of your child. How did you hear about us:** \_\_\_\_\_

Acorn Pediatrics Office Use Only

Verify ID: Driver's License Other \_\_\_\_\_ Employee signature: \_\_\_\_\_