

Sierra Pediatrics

Registration Form

PATIENT INFORMATION				
Patient Name:	Social Security #	Date of Birth:	Sex:	Child Lives with:
1.			M / F	<input type="checkbox"/> Mom, <input type="checkbox"/> Dad, <input type="checkbox"/> Both
2.			M / F	<input type="checkbox"/> Mom, <input type="checkbox"/> Dad, <input type="checkbox"/> Both
3.			M / F	<input type="checkbox"/> Mom, <input type="checkbox"/> Dad, <input type="checkbox"/> Both
4.			M / F	<input type="checkbox"/> Mom, <input type="checkbox"/> Dad, <input type="checkbox"/> Both
PARENT/GUARDIAN INFORMATION				
Marital Status:				
Relationship to Child:		Relationship to Child:		
Name:		Name:		
Home Address:		Home Address:		
City, State Zip:		City, State Zip:		
<input type="checkbox"/> Mailing address is different than Home address		<input type="checkbox"/> Mailing address is different than Home address		
Home Phone:		Home Phone:		
Cell Phone:		Cell Phone:		
Birth Date:		Birth Date:		
Social Security #:		Social Security #:		
Employer Name:		Employer Name:		
Work Address:		Work Address:		
City, State Zip:		City, State Zip:		
Work Phone:		Work Phone:		
Occupation:		Occupation:		
EMERGENCY CONTACT INFORMATION: NOT A PARENT/GUARDIAN				
Emergency Contact:		Contact Phone:	Contact Second Phone:	
Relationship to Patient:				

_____ **Acknowledgment of Notice of Privacy Practices**
 Initials I hereby acknowledge that I have been presented a copy of the Sierra Pediatrics Privacy Policy effective 10/1/05. Sierra Pediatrics reserves the right to change this notice of privacy practices at any time. A current notice of privacy practices will always be available upon request.

_____ **Acknowledgment to Treat**
 Initials I give Sierra Pediatrics authorization to evaluate and treat my child. Except in cases of emergency, operations or procedures will not be performed until you have had the opportunity to receive information and have given your consent. Depending on the type of treatment, consent may be verbal or written. Sierra Pediatrics does not evaluate or treat patients after their eighteenth birthday.

_____ **Authorization to Complete Daycare / School Physical Exam Forms and to Notify the Washoe County Health Department with Vaccination Information**
 Initials Upon request by Patient's Legal Representative, Sierra Pediatrics is authorized to release medical health information by completing and/or submitting daycare or school medical forms.

The above information is true to the best of my knowledge. I am the legal parent or guardian of the patient listed above. I authorize my insurance benefits to be paid directly to Sierra Pediatrics. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize Sierra Pediatrics and my insurance company to process my claims. I have had the opportunity to ask questions regarding the above information.

X

 Parent/Guardian Signature

_____ Date