Child's Name First _______________ Middle ______________ Last ___________________________
Date of Birth ________________ Sex _____________ SSN ______________________________
Primary Address ____
Phone # _________________ Race ___________ Ethnic Group: (Circle One) Latino Non-Latino

Mother's Name ___________________________________ Date of Birth __________________
Address (if different from child) ____
Home Phone _________________________ Cell phone _________________________________
Email Address ____________________________________ SSN __________________________
Is this person authorized to discuss health information for the patient? YES or NO

Father's Name ___________________________________ Date of Birth __________________
Address (if different from child) ____
Home Phone _________________________ Cell phone _________________________________
Email Address ____________________________________ SSN __________________________
Is this person authorized to discuss health information for the patient? YES or NO

Who is the child's Legal Guardian? ________________________ Date of Birth ____________
Relationship to child _____________ Email Address ____________________________
Address (if different from child) ____
Home Phone __________________________ Cell Phone _______________________________

EMERGENCY CONTACT / HIPAA CONTACT (Please list someone not named already)
Name _________________________________ Relationship to child ______________________
Phone ________________________________
Name _________________________________ Relationship to child ______________________
Phone ________________________________

INSURANCE INFORMATION
Primary Insurance Name ___________________________ Plan name ____________________
Policy Number _______________ Group Number _______________ Group name ___________
Claims address __________________________________ Phone number _________________
Policy Holder's Name ______________________________ Date of Birth __________________
SSN ______________________________

Secondary Insurance Name ___________________________ Plan name ____________________
Policy Number _______________ Group Number _______________ Group name ___________
Claims address __________________________________ Phone number _________________
Policy Holder's Name ______________________________ Date of Birth __________________
SSN _______________________________

Please give our receptionist your insurance card(s) to copy. We must have a copy of your cards to file your insurance. Due to insurance contact requirements, we collect the patient's portion at the time of service.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: ______________________________ **Date of Birth:** _____________

First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of insurance benefits to The Ark Children's Clinic for services rendered to my dependents by the physician/provider or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services to be received are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that The Ark Children's Clinic is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of The Ark Children's Clinic Patient Information Privacy Policy. I hereby authorize The Ark Children's Clinic to release any of my or my dependent's medical or incidental non- public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a The Ark Children's Clinic representative or my physician/provider to mail, call, or e-mail me with communications regarding my child's health care including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at anytime by notifying The Ark Children's Clinic to that effect in writing.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by The Ark Children's Clinic or his or her designee for my child. Please list all persons/HIPAA contacts who may have access to your child's medical information. *Example: bring child to appointments and authorize lab work/immunizations/testing, etc, prescription pick up, general medical information, lab results and medical emergencies.*

If their name is not on the list, they will not be allowed to have any information on the patient. Please make sure to update any changes at each appointment.

Our office will ask to make a copy of their photo I.D. when bringing your child into the office.

Name	Relationship to Patient
1.	
2.	
3.	
5.	

PATIENT SIGNATURE (age 18 or older): ________________________ **DATE:** ____________________

PARENT NAME (Please Print) ____

PARENT SIGNATURE: __________________________________ **DATE:** _________________________
(If different from patient)