Patient Registration Form

Patient Information

Name (first and last): ______________________________ Date of Birth: ____________________ Sex: ________

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Contact Information

Mom's Name: ____________________ Phone: ____________ Dad's Name: ____________________ Phone: ____________

Patient's Primary Address: ______________________________ City: ____________ State: ______ Zip: ________

Email used for portal/vaccine records/appt reminders/statements (only one): ______________________________

What phone number would you like **text appointment reminders** sent to? ______________________________

Pharmacy Name: ______________________________ Location (Cross Streets): ______________________________

Billing Information

Who carries the insurance: ____________________ Relationship: ____________________ Date of Birth: ____________________

What phone number would you like **billing statements** sent to? ______________________________

Address for billing notices and refunds: ______________________________

Please note all statements will be sent via text message and email. We no longer send out monthly paper statements.

Authorization for Treatment

I give consent for the following people to bring my child in for an appointment, to request services and treatment, and to obtain all medical records should I not be present. If the patient is 18+, please list your parents if you wish to share medical information with them.

Name: ______________________________ Phone: ____________________ Relationship to Patient: ____________________
Name: ______________________________ Phone: ____________________ Relationship to Patient: ____________________

Privacy Notice

A notice of Privacy Practices (NPP) is available for your review or you may take it with you. The NPP describes our effort to protect the privacy of your personal health and financial information. The NPP also describes how such information may be used, released or shared under the Health Insurance Portability and Accountability ACT (HIPPA). Copies of the NPP are available upon request.

By signing below, you authorize Clown Pediatrics to call, leave a message, and/or text the phone numbers listed on this form. If there are any changes to the above information, it is the parent's responsibility to notify the office of those changes.

Clown Pediatrics has my permission to use my child's photo in their office., on their website, or on their Facebook page.

Please Check: ____ Yes or ____ No

Signature: ______________________________ Date: ____________________

Relationship to Patient (Parent/Guardian/Self if 18+): ______________________________

Follow us on Facebook to stay up to date on office hours, get notified of health and safety updates, and get to know the staff.

For Staff Use Only signature date _____ vfc eligibility/package c _____ all siblings _____ staff initials _______

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