Happy & Healthy Pediatrics

Pediatric, Adolescent, & Breastfeeding Medicine

Patient Registration Form

Patient

Patient's Full Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Patient's Address_____ Patient's Home Tel# _____ -- _____ -- _____

City, State, Zip _____

How did you hear about our practice? / I was referred by: _____

Family's main e-mail address: _____

Insurance Carrier and Primary Card Holder: _____ _____

Siblings

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Parent 1 ☐ Lives with Patient

Parent 1 Full Name _____ Parent 1 Parent 1 Work Tel # _____ -- _____ -- _____ Parent 1

Maiden Name _____ Cell Tel # _____ -- _____ -- _____

Parent 1 Address (if differs from above): Parent 1 Date of Birth _____ / _____ /_____

_____ Parent 1 Employer / Occupation _____

Parent 2 ☐ Lives with Patient

Parent 2 Full Name _____ Parent 2 Work Tel # _____ -- _____ -- _____

Parent 2 Address (if differs from above): Parent 2 Cell Tel # _____ -- _____ -- _____ Parent

_____ 2 Date of Birth _____ / _____ / _____ Parent 2

Employer / Occupation _____

Custody: Parent 1 ☐ Parent 2 ☐ Joint ☐

Emergency Contact

Contact's Full Name _____ Contact's Relationship to Patient _____

Contact's Tel # (1st) _____ -- _____ -- _____ Contact's Tel # (2nd) _____ -- _____ -- _____

Authorizations and Consents:

☐ (**Please check**) I authorize treatment (in person, virtually or telephonically) of the patient named above, and all family members, by Happy and Healthy Pediatrics, PC. I authorize the release of medical records necessary to process insurance claims and to other medical providers involved in my child's/children's care. I authorize payment of medical benefits to be made directly to Happy and Healthy Pediatrics, PC.

☐ (**Please check**) I have been presented with a copy of the updated 2013 Notice of Privacy Practices for the office of Happy and Healthy Pediatrics, PC detailing how my information may be used and disclosed as permitted under federal and state law. This notice applies for all members of the family.

Yes / No I would like to receive updates, messages relating to my child's healthcare, general office information, etc. via e-mail.

Signature _____ Date _____ /_____ / _____

Name (Print) _____ Relationship to patient (circle one): Mother Father Legal Guardian

77 JERICHO TURNPIKE, SUITE 175 MINEOLA, NY 11501

{t} 516 216 5910 {f } 516 216 5907

www.happyandhealthypediatrics.com