

Syracuse Pediatrics Registration Form

Patient Information

	DATE	
Name	Date of Birth	_____
Soc. Sec. #	Male or Female	_____
Address	City/State/Zip	_____
Home Phone	Cell/Other phone	_____
Email		_____

Mother's Information

Name	Date of Birth	_____
Maiden Name	Soc. Sec. #	_____
Address	City/State/Zip	_____
Home Phone	Cell/Other phone	_____
Email		_____
Employer	Work Phone	_____
Position		_____
Employer Address		_____

Father's Information

Name	Date of Birth	_____
Soc. Sec. #		_____
Address	City/State/Zip	_____
Home Phone	Cell/Other phone	_____
Email		_____
Employer	Work Phone	_____
Position		_____
Employer Address		_____

Insurance Information

Primary Insurance Company Name		_____
Policy ID #	Group #	_____
Policy Holder Name	Date of Birth	_____
Relationship to patient		_____

Secondary Insurance Company Name		_____
Policy ID #	Group #	_____
Policy Holder Name	Date of Birth	_____
Relationship to patient		_____

Emergency Contact

Name	Phone Number	_____
Relationship to patient		_____

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HIPAA DOCUMENTATION

Please answer all of the questions below and then sign and date. Thank you.

I acknowledge that I have been given the opportunity to read and/or receive a copy of Syracuse Pediatrics' Privacy Notice.

Yes

No

Is anyone else authorized to bring your child in for medical care? If so, please list their name, relationship & phone #.

Is anyone else authorized to discuss your child's care with us? If so, please list their name, relationship & phone #.

May we leave appointment messages or other medical information on :

Answering machine Yes No

Office voice mail Yes No

With persons listed above. Yes No

I certify that the above information is correct and true to the best of my knowledge. I understand that failure to provide any missing information may result in my being responsible for payment of services rendered to my child.

Date: _____

Signature: _____

I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Date: _____

Signature: _____

I authorize payment of medical benefits to above stated physician or supplier for services rendered.

Date: _____

Signature: _____