

New Guest Registration Form

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| **General Information (please print)** |
| Guest Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ethnicity (circle one):** Hispanic or Latino Non-Hispanic or Latino**Race (circle one):** American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Other Address (where child lives): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_ **Mother’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address (if different than child’s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Father’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address (if different than child’s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Legal Guardian’s Name** (if applicable)**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Emergency contact** (If parent unavailable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_ **Pediatrician’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_ |
| **Guarantor’s Statement of Financial Responsibility**Guarantor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand that I am personally responsible for the payment of this patients account.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Primary Insurance**  |
| Insurance name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Sec # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Secondary Insurance**  |
| Insurance name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Sec # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Patient Phone Message Consent** |
| It is our policy to notify you of test results ordered by this office. This is to acknowledge that you authorize us to: * Leave a detailed message on voice mail/machine/cell YES \_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_ (initial yes or no)
* Leave a detailed message with individual answering the phone YES \_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_ (initial yes or no)
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| **Authorization to Release Medical Records** |
| I hereby authorize the release of a copy of all my medical records, including but not limited to vaccine records, progress notes, labs, and diagnostic tests to my child’s pediatrician/specialists and any additional specialists/hospitals if requires for my child’s care.Parent (or guardian) signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Patient Authorization for ePRESCRIBE**  |
| ePrecribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of Over the Rainbow to enroll me in the ePrescribe Program. Pharmacy name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient (or guardian) signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Patient Authorization for CONSENT TO TREAT**  |
| **I have the legal right and responsibility to obtain and consent to medical treatment for this patient.** I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Over the Rainbow Pediatric Urgent Care Providers believe are necessary for this child. I understand that by signing this form, and by bringing this child to this medical office for care, I am giving permission to the doctor and other health care providers in this office to provide any necessary treatment to this patient. **DELEGATION OF CONSENT (This section is OPTIONAL. Include adults other than parents/legal guardians)** I hereby authorize (when I am unavailable to give consent) to the following individual(s): Name of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_This delegation shall be valid until I withdraw this delegation of consent. Patient (or guardian) signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Patient Authorization for ALL PATIENTS**  |
| I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. Patient (or guardian) signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**  |
| Notice to patients: We are required to make available to you a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. ***I acknowledge that I have been offered a copy of the OTRPUC’S Notice of Privacy Practices.*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed name Signature Date signed  |

How did you learn about Over the Rainbow Pediatric Urgent Care?