Pediatric Wellness of Northern New York

19474 Howell Drive, Watertown NY, 13601

Tel: (315) 782-7330 · Fax: (315) 782-5773

PATIENT REGISTRATION FORM

Patient Name:_____ DOB: _____

Patient Adress: _____

☐ MALE ☐ FEMALE Patient SS# _____-_____-_____

Gender Identity Optional): _____

Race (optional): American Indian/Alaskan Native, Asian, Black/African American, Hawaiian/Pacific Islander, White, Other Decline/Refuse to Answer/Unknown

Ethnicity: Hispanic Non-Hispanic **Primary Language:** _____

Parent/Guardian Demographics

Mother's Name _____**Father's Name** _____

Address: _____ Address: _____

_____ _____

DOB: _____ SSN# _____ DOB: _____ SSN# _____

Phone number: _____ Phone Number:_____

Cell Phone:_____ Cell Phone: _____

Legal Guardian Name: _____ DOB: _____ SSN# _____

(IF OTHER THEN BIOLOGICAL PARENTS)

Phone number: _____ Cell Phone: _____

Responsible Party Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

E-Mail for portal use: _____

Insurance Information

Primary Insurance: _____ ID# _____Effective Date:_____

Policy Holder: _____ DOB: _____ Employer: _____

Secondary Insurance: _____ID# _____ Effective Date: _____

Acknowledgement of Receipt of Privacy Practices

I, _____ have read **PEDIATRIC WELLNESS OF NORTHERN NEW YORK PC** Notice of privacy practices effective April 14, 2003.

Signature: _____ Date: _____

Advanced Beneficiary Notice (ABN)

Your health insurance may only pay for certain items(s), or services (s) offered through our practice. The plan you have chosen as your health insurance does not necessarily cover all your health care cost. Insurance only pays for covered items and services. Covered and non-covered items and services can be found in your health insurance contract or by contacting your health insurance plan. We do not know your health insurance plan and it is your responsibility to know whether certain items or services are or are not covered. The fact that your health insurance plan may not pay for a particular service does not mean that you should not receive them, especially if your physician recommends that you should receive the items or services.

Signature: _____ Date: _____

Pediatric Wellness of Northern New York Office Policies

- I authorize the release of any medical or necessary information to the insurance company to process any insurance claims.
- I authorize payment of medical benefits to **PEDIATRIC WELLNESS OF NORTHERN NEW YORK, PC.**
- I authorize **PEDIATRIC WELLNESS OF NORTHERN NEW YORK, PC** to provide medical treatment to my child.
- I authorize the release of my child's immunization records and physical to his/his school per my request.
- I understand three (3) or more missed appointments may lead to dismissal.
- I understand that a parent or guardian must always be present at the time of appointment for ages under 18years.
- I give Pediatric Wellness of Northern New York permission to send out my child's cultures or nasal swabs to Samaritan Medical Center at 830 Washington St, Watertown NY 13601 for testing.

Signature: _____ Date: _____

OFFICE USE VERIFIED/ENTERED BY: _____