Patient Registration

Patient ______________________________ Sex: ❑ M ❑ F DoB____/____/____ SS#__________________

Language __________________ Race __________________ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling ______________________________ Sex: ❑ M ❑ F DoB____/____/____ SS#__________________

Language __________________ Race __________________ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling ______________________________ Sex: ❑ M ❑ F DoB____/____/____ SS#__________________

Language __________________ Race __________________ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling ______________________________ Sex: ❑ M ❑ F DoB____/____/____ SS#__________________

Language __________________ Race __________________ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Mother/Guardian ______________________________ DoB____/____/____ SS#__________________

Address ______________________________ Home Phone __________________

City/State/Zip ______________________________ Email__________________

Work Phone __________________

Employer ______________________________ Occupation __________________

Father/Guardian ______________________________ DoB____/____/____ SS#__________________

Address ______________________________ Home Phone __________________

City/State/Zip ______________________________ Email__________________

Work Phone __________________

Employer ______________________________ Occupation __________________

Children live with: ❑ Mother ❑ Father ❑ Guardian ______________________________

Emergency Contact:

Someone that does not live in home: ______________________ Relation __________ Phone __________

What Pharmacy do you use/Location: *(Kroger on Madison)* ______________________________

INSURANCE INFORMATION

Primary__________________ Policy #__________________ Insured Name __________________

Secondary__________________ Policy #__________________ Insured Name __________________

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT

I authorize Rainbow Kids Clinic to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Rainbow Kids Clinic for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care of immunizations cannot be given unless my child is accompanied by one of the following:______________________________

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the the human immunodeficiency virus (HIV) or hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature ______________________________ Relation __________ Date__________