Concord Children's Clinic
1040 Vinehaven Drive • Concord, NC 28025

PATIENT REGISTRATION FORM

Patient's Name_____
(Last) (First) (Middle) (Goes By)

Date of Birth (DOB) _____ Sex_____Age_____

Patient's Social Security #_____ Allergies_____

Race / Ethnicity_____Language Preference_____

Preferred Email Address_____Preferred Provider_____

Mother's Name_____

Home Phone_____Cell Phone_____

Home Address_____
City State Zip

Employer_____Work phone_____

Social Security #_____

Father's Name_____

Home Phone_____Cell Phone_____

Home Address_____
City State Zip

Employer_____Work phone_____

Social Security #_____

Emergency Contact #1_____

Relationship_____Phone #_____

Emergency Contact #2_____

Relationship_____Phone #_____

CONSENT FOR TREATMENT

CONSENT TO TREAT: Permission for evaluation and treatment granted whether child presented by parent, other family member, unrelated third party or unaccompanied.

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

Signed _____Relationship _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I herby authorize Concord Children's Clinic to furnish any necessary information concerning my child, _____ to my insurance carriers, to other medical personnel to whom physicians have referred my child for treatment; to admitting hospital should my child be admitted for treatment. I understand that Concord Children's Clinic may use or disclose my child's personal health records when required by law.

Signed _____Relationship _____ Date _____

ASSIGNMENT OF INSURANCE /LIABILITY BENEFITS: I understand that my child's insurance information and payment is due at the time of the service. Patients covered under a contracted insurance plan are required to pay co-payment, deductible or co-insurance at the time of the service. Patients covered under non-contracted insurance plans are responsible for filing all charges with their insurance carrier. NOTE: Divorce has no bearing on the responsibility for medical care as it affects third parties. Whoever brings the child is expected to pay the charges due for the service rendered that day unless we have copy of the court orders stating otherwise. Concord Children's Clinic does not get involved in payment disputed between parents. I understand that insurance/ Medicaid cards should be presented at every visit.

Signed _____Relationship _____ Date _____

ACKNOWLEDGEMENT FORM

We are required by law to provide you with our Notice of Health information Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

☐ I have been provided a copy of Concord Children's Clinic Notice of Health Practices

Signature_____ Date_____

Relationship to patient_____

Reason Patient unable/unwilling to sign _____