Concord Children's Clinic
1040 Vinehaven Drive NE, Concord NC 28025
Phone: 704-784-1010 Fax: 704-784-1013
www.ConcordChildrensClinic.com

How Did You Hear About Our Clinic (check one):

☐ Have Another Child at Clinic ☐ Friend / Word of Mouth ☐ Internet Search
☐ School / Daycare ☐ No Availability Elsewhere ☐ Public Event (which one?) _____

PATIENT REGISTRATION FORM

Patient Information

Patient Name

(First) (Middle Initial) (Last)

(Date of Birth) (Age) (Social Security Number)

(Race / Ethnicity) (Preferred Language) (Gender at Birth)

Legal Guardian Information

(Note: primary contact will be the first form of contact for the patient)

(Primary Contact - Legal Guardian Name)

(Relationship to Patient)

(Mailing Address)

Primary Phone # Home / Work / Mobile

(Alternate Phone # Home / Work / Mobile

(Email Address)

(Date of Birth)

(Social Security Number)

(Secondary Contact - Legal Guardian Name)

(Relationship to Patient)

(Mailing Address - or "Same")

Primary Phone Home / Work / Mobile

(Alternate Phone Home / Work / Mobile

(Email Address)

(Date of Birth)

(Social Security Number)

Check Mark or Answer Columns below:

	Primary Contact	Secondary Contact
Who does the child reside with?	☐	☐
Who has legal custody of child? *(Please Provide Legal Documents For Verification)*	☐	☐
Who is responsible for medical bills?	☐	☐
Who has access to medical records?	☐	☐
Is it OK to leave a message for the contact?	☐	☐
Which is the preferred method of communication (phone or email?)	☐	☐

Other (Emergency) Contacts

(other than guardian if applicable)

Name _____ Name _____

(Relationship to Patient) _____ (Relationship to Patient) _____

(Primary Phone #) (Home / Work / Mobile) _____ (Primary Phone #) (Home / Work / Mobile) _____

(Alternate Phone) (Home / Work / Mobile) _____ (Alternate Phone) (Home / Work / Mobile) _____

Authorization for Release of PHI (Protected Health Information)

Concord Children's Clinic is authorized to release PHI regarding the above-named patient to entities named below. Your PHI included general health information, laboratory tests and billing information. The purpose is to inform the patient or others in keeping with the patients' instructions.

How would you prefer that we communicate your PHI if you cannot be reached directly?

(Print Name) (Phone Number) (Home / Work / Mobile)

Is it OK to contact you by phone and/or leave you a detailed message in your voice mail? (check one) YES ☐ NO ☐

If over 18 yrs., is It OK to leave detailed messages with anyone other than yourself (ex: spouse, partner, parents, please provide their name and phone number.

Name of Person _____ (Phone #) _____

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may not longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be condition.

I have reviewed and understand the PHI information stated above.

Signature _____ Date _____