

Genesee-Transit Pediatrics

Registration Form

In order to serve you properly, we will need this form completed. All information is confidential.

Patient Name: _____ Birth Date: _____

Sex: Male / Female (please select one) Phone: (____) _____

Address: _____ City: _____ State: _____ Zip code: _____

Primary Language: _____ Country: _____ Secondary Language: _____ Country: _____

Ethnicity: Spanish/Hispanic: _____ Not of Spanish/Hispanic: _____ Declined/Unknown _____

Ancestry: _____ Asian _____ American Indian/ Alaska Native _____ Black/ African American _____ Native Hawaiian/Pacific Islander
_____ White _____ Other _____ Declined/Unknown _____

Relationship between Mother and Father: Married: _____ Separated: _____ Divorced: _____ Other: _____

Who has legal custody of this patient? _____

What pharmacy do you typically use? _____ Phone: (____) _____

Parent email use for patient portal: _____

Parent: Mother _____ Maiden Name:(Immunization Registry): _____

Guardian/other-name: _____ Indicate relationship: _____

Address: _____ City: _____ State: _____ Zip code: _____

Birth Date: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Phone: (____) _____

Parent: Father _____

Guardian /other-name: _____

Name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Birth Date: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Phone: (____) _____

I hereby request and authorize Genesee-Transit Pediatrics to provide and perform such medical / surgical care, tests, procedures, medications, and other healthcare services as are considered necessary or beneficial for my child's health and well being.

_____ Date _____

(Signature of Parent/ Legal Guardian)

Insurance Information

Note-Is patient's current insurance and copy of card on file with us? _____ If so do not complete below.

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Name of Subscriber: _____ Birth Date: _____

It is your responsibility to provide accurate and up to date medical insurance information to us and to notify us of any changes in your insurance coverage. You will be invoiced directly if your insurance denies coverage or if we do not have insurance changes/information that results in a timely filing denial.

You are responsible for and expected to pay promptly all co-payments, co-insurance or unpaid deductibles at the time of service. The person bringing in the child regularly is considered the responsible party regardless if they are the subscriber of the insurance.

I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company necessary to process insurance claims for the services rendered by the practitioners of Genesee-Transit Pediatrics, LLP. I hereby authorize the above insurance company to distribute the payment of my dependent's medical coverage directly to the provider rendering services.

Print Name of Parent/Legal Guardian

Date _____

Signature of Parent/Legal Guardian

Emergency Contact

I further authorize (where applicable) the following relatives / friends to bring my child in for healthcare if I am not available.

***Please note**-this does not allow the emergency contact to have access to medical or billing information whenever they call. This is for sick visits and/or a way to contact you if we have do not have any other way to get a hold of you.

1) _____ / _____ 2) _____ / _____
Emergency Contact (Relationship to patient) (phone number) Emergency Contact (Relationship to patient)(phone number)

Date _____

(Signature of Legal Guardian)