New Patient Registration Form

Date: _________

Patient Name: __________________________ DOB: __________
Address: ______________________________ City: _______________ State: ______ Zip: ________
_____________________________________ Sex: ___M ___F SSN: _____-____-______

Race/Ethnicity

__American Indian / Alaska Native __Asian __African American/Black __Caucasian/White
__Hispanic __Native Hawaiian / Other Pacific Islander __Other
Primary Language: _____________

Primary Contact Number:( ) ____-________ Secondary Contact Number: ( ) _____-__________

Previous PCP: ______________________________
PCP Phone: ( ) ____- ______ PCP Fax: ( ) ____- _______

How did you hear about us: (*please check one*)
☐Friends / Family ☐Magazine ☐Web ☐Other ________________________

Mother's Name__________________________
SSN____________________ DOB__________
Address_______________________________
City___________ State_______ Zip________
Phone____________ Work Phone__________
Employer______________________________
****
Emergency Contact_______________________
Phone ( ) ____-________
Relationship to Patient______________________

Father's Name______________________________
SSN_____________________DOB____________
Address____________________________________
City____________ State_______ Zip___________
Phone_____________ Work Phone____________
Employer___________________________________

Pharmacy Information

Pharmacy Name: ___________________________ Location: ________________________

PATIENT PORTAL COMMUNICATION

Use of Electronic Communication from ZÖe Pediatrics to the Patient

☐ **YES**, I want ZÖe Pediatrics to communicate my child(ren)'s information with me through a secure patient portal system that is designed to keep medical information safe. You will be notified by email when there is secure information for you to review. The email will provide a link that will take you to your patient portal. After clicking the link, you will be required to log in and enter a password to access your information. You will need to make note of the password to access any future information.

***** Please enter in the space below the email address you would like to use to be notified of secure messages *****

____
Email Address (please print clearly)

In choosing your email address, please consider the privacy implications. For example, any other person that may have access to your email address, such as an employer, may have the right and/or ability to review any email you receive.

☐ **NO**, I do not want ZÖe Pediatrics to use electronic communication as a way to communicate my child(ren)'s information to me. I understand that copies of lab results, physician statements, and shot records I request to be printed, faxed, and/or mailed may incur a fee.

Please list all children living in the child's home

Name	Relationship to Patient	Date of Birth

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INSURANCE INFORMATION

Primary Insurance

Policy Holder Name___________________________
Insurance Company___________________________
Address_____________________________________
____
Phone (   ) ____- _________
Effective Date ___/___/____
Subscriber #__________________________
Group #___________________________

Secondary Insurance

Policy Holder Name_________________________
Insurance Company_________________________
Address___________________________________
____
Phone (   )____- _________
Effective Date ___/___/____
Subscriber #______________________________
Group #__________________________

Financial Responsibility for Services Rendered by ZÖe Pediatrics Physicians

I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been processed and paid. I further understand that if my claim is not accepted for payment. I am personally responsible for payment of medical services rendered to myself or a member of my family.

I acknowledge that medical billing statements for services rendered by ZÖe Pediatrics Physicians will be sent to the person who carries the insurance for the patient/family member.

- I understand that I am responsible for the accuracy of the information I have provided on this form.
- I authorize payment of medical benefits to be made directly to ZÖe Pediatrics.
- I authorize the release of medical records necessary to process insurance claims.
- I authorize the release of correspondence and/or medical records to payers involved in my child's care.
- I have read and understand the Financial Policy.

____

print name) ***(signature)*** ***(date)***

☐Self ☐Parent ☐Legal Guardian (*Please Select One*)

If you are not the parent of the patient, you will need to provide a "Placement Letter" that includes the state of GA / Al letterhead, or a court order signed by a judge.

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LATE TO APPOINTMENT POLICY

We value your time and strive to see you as close to your appointment time as possible. Recognizing unanticipated things happen, we will hold your appointment for a 15 minute grace period after the scheduled start time of your appointment. In consideration of every patient, all appointments will be automatically canceled thereafter. If you arrive after your appointment has been cancelled, you will be asked to either reschedule the appointment or wait to be seen as a 'Walk-In" patient.

Please place a check mark in EACH BOX indicating your consent:

☐ YES ☐ NO **AUTHORIZATION TO LEAVE MESSAGE**

I hereby authorize ZÖe Pediatrics to leave a message regarding appointments or tests at my residence or cell phone. It is my responsibility to provide ZÖe Pediatrics with the most up to date contact information.

☐ YES ☐ NO **AUTHORIZATION TO SEND APPT REMINDERS**

I hereby authorize ZÖe Pediatrics to send appointment reminders or other alerts via text message or automated voice message. It is my responsibility to provide ZÖe Pediatrics with the most up to date contact information.

☐ YES ☐ NO **PHOTO CONSENT**

I hereby authorize ZÖe Pediatrics providers and/or staff to take and use photographs of my child/ren on educational purposes, which may include submissions in publication(s), website(s), brochure(s), and other social media.

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CONSENT FOR CONTINUING TREATMENT OF MINOR CHILD

I, the parent/ guardian of ____, a minor child, do hereby consent
(child's full name)
to any diagnosis or treatment rendered under the general or specific instructions of physicians at ZÖe Pediatrics. This consent is given in advance of any specific diagnosis or treatment being required, and it is given to encourage those persons who have temporary custody of my child, and said physician(s), to exercise their best judgment as to the requirements of such diagnosis or medical treatment.

This consent shall remain effective until revoked in writing and delivered to said physician or to said persons entrusted with the custody, care and control of said minor child.

Person authorized to bring the child to medical appointments:

1) ____relationship __________________________________
2) ____relationship __________________________________
3) ____relationship __________________________________

Legal Guardian:____
(print name) *(signature)* *(date)*

This authorization will remain active, unless a written statement is received by the parent/guardian to revoke an authorized person.

NOTICE OF PRIVACY PRACTICES

I _________________________________ acknowledge that I have been given a copy of ZÖe Pediatrics Notice of Privacy Practices Documentation.

Signature: ________ ____Date ____/____/_____