**PATIENT REGISTRATION**

**Email address for appointment reminders: _____**

**Cell Phone # *AND CARRIER NETWORK* for appointment reminders: _____**

**PATIENT INFORMATION:**

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

DATE OF BIRTH: _____ SEX: MALE ____ FEMALE ____ SOCIAL SECURITY # _____

STREET ADDRESS: _____ APT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____ HOME PHONE: _____

**FATHER'S INFORMATION:** *** FILL OUT COMPLETELY ***

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

STREET ADDRESS: _____ APT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____

**MOTHER'S INFORMATION:** *** FILL OUT COMPLETELY ***

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

STREET ADDRESS: _____ APT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____

**EMERGENCY CONTACT: _____ HOME PHONE: _____ CELL PHONE:_____**

As pediatricians, we wish to provide your child with the best care possible. We may order certain routine laboratory tests and routine vaccinations that we feel are necessary for the maintenance of good health but that may not be covered by your insurance contract. You will be expected to pay for these services in full. We follow the American Academy of Pediatrics guidelines for child health maintenance and will only order a test if we truly believe that it is necessary for your child's health. I, the parent or guardian of the above child do, hereby authorize Acton Road Pediatrics, LLC, and all of its physicians to give to this child immunizations and treatments that such physicians deem necessary for his/her health.

I authorize the release of medical information on this child to other physicians and insurance providers as necessary for my child's care and in compliance with federal HIPAA policies. I acknowledge that I am totally responsible for all charges for services rendered to this child including non-covered services. If this account is referred to a collection agency or attorney for collection, I agree to pay all costs of collection. A returned check fee of $30 applies to all returned checks.

**RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____**