**BRIGHAM/FARR WEST PEDIATRICS REGISTRATION FORM**

**Patient Name(s): Please list all your kids.**

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_/\_\_\_/\_\_\_ Sex\_\_\_

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_/\_\_\_/\_\_\_ Sex\_\_\_

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_/\_\_\_/\_\_\_ Sex\_\_\_

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_/\_\_\_/\_\_\_ Sex\_\_\_

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_/\_\_\_/\_\_\_ Sex\_\_\_

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_/\_\_\_/\_\_\_ Sex\_\_\_

**Ethnicity:** Hispanic/Latino Not Hispanic Other \_\_\_\_\_\_\_\_\_\_ Language**:**  English Spanish Refuse

**Please circle Race:** Caucasian, Black, Asian, American Indian, Hispanic, Refuse, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

**Legal Parent/Guardian (Primary Contact)**

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_ /\_\_\_ /\_\_\_\_

Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_ Sex\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (for insurance purposes)

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Cell Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_ E-Mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Parent/Guardian (Secondary Contact)**

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_ /\_\_\_ /\_\_\_\_

Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_ Sex\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (for insurance purposes)

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Cell Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_ E-Mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stepparent/Other:**

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_ /\_\_\_ /\_\_\_\_

Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_ Sex\_\_\_\_ Cell Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Primary\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_\_

Secondary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_\_

**In Case of Emergency:**

Name of person not living with you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Cell Phone Number (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list the names of others who are authorized to bring your child to the appointments on your behalf.**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT TO TREAT: I authorize the physician or providers the physician or provider in charge of the care of the above-named patient to administer such anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed advisable in the diagnosis and treatment of this patient. FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she hereby individually obligates themselves to pay the account of the clinic. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay reasonable attorney’s fees and collection expenses. ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to the clinic or its agent, insurance benefits otherwise payable to me. RELEASE OF INFORMATION: The clinic or its agent may disclose all or part of the patient’s record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the charge.

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date: \_\_\_/\_\_\_/\_\_\_\_

RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOU ARE THE PATIENT AND 18 YEARS AND OLDER, PATIENT MUST SIGN AND PRINT**

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date: \_\_\_/\_\_\_/\_\_\_\_