

THE MARYLAND PEDIATRIC GROUP, LLC/PEDIATRIC CONSULTANTS, P.A.
Patient Registration

Date: _____ Primary Care Doctor: _____

Referring M.D. (Dr. Schuberth and Jane Spath patients only):
_____ Phone: _____

Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

In order to participate with The American Recovery and Reinvestment Act (ARRA) we are required to obtain this information.

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Mailing Address:

(Street or PO Box)

(City)

(State & Zip)

Home Phone: (_____) _____ - _____

Who lives at this household? _____

Insurance:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____

ID# _____ Group # _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____

Insurance Carrier: _____

ID# _____ Group # _____

Contact 1 (Person Pt lives with): Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home e-mail / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email

Contact 2: Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here: _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Emergency Contacts, other than parents: Name & Relationship

1: _____ Phone: (____) _____ - _____

2: _____ Phone: (____) _____ - _____

Assignment of Benefits: I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company (s), I will be held directly responsible for all fees incurred with The Maryland Pediatric Group L.L.C./Pediatric Consultants.

I understand that I am responsible for copayments, coinsurance, deductibles or services not covered by my insurance. I acknowledge that I am responsible for payment in full in the event the provider of services does not participate with my insurance plan. I also understand that I am responsible for providing a referral form at the time of service (before services are rendered) if required by my insurance plan. If I elect to see the provider of services without the necessary referral form, I understand that I am responsible for payment in full at the time of service and that my insurance may deny my claim. I authorize payment of medical benefits to the physician or provider for all services rendered. I also authorize the release of any medical information requested for the processing of the claims for myself (or my minor child).

I have received information regarding the privacy practices of The Maryland Pediatric Group L.L.C./Pediatric Consultants as it relates to me or my child(ren) as defined by state and federal regulations.

Parent/Guarantor/LegalGuardian _____ Date _____

I am 18 years of age or over and give my parent's permission to discuss my medical history with my physician.

Patient Signature _____ Date: _____

Print Name _____