NASA PEDIATRICS-NEW PATIENT REGISTRATION

PATIENT DEMOGRAPHICS:

PATIENT FULL NAME: ____

DOB: _____________________ SEX: M_____ F_____ PRIMARY LANGUAGE: _____________________________

ADDRESS: ____

CITY: ____________________________________ STATE: ______________ ZIP CODE:________________________

FATHER'S NAME: _____________________________ MOTHER'S NAME: __________________________________

FATHER'S PHONE: ____________________________ MOTHER'S PHONE: _________________________________

EMERGENCY CONTACT: (PLEASE LIST AT TWO CONTACTS WHO DO NOT RESIDE IN THE SAME RESIDENCE IN CASE WE ARE UNABLE TO CONTACT PARENTS/GUARDIANS)

1. Name:_______________________________________ Phone :___________________________________
2. Name:_______________________________________ Phone :___________________________________

PRIVACY PRACTICES AND CONSENT TO TREAT

_____________ *(INITIALS)* I have reviewed the NASA Casa De Niños notice of privacy practices, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document. I, Parent/Guardian of above named child, give authorization to NASA Pediatrics to provide medical evaluation and treatment. I understand, that my child must be present with a parent/guardian at all times during consultation. I authorize the following person(s) to consent for any/all medical treatment and/or procedures if I am unable to bring my child in. (Must be at least 18 years of age)

1. **Name:___________________________________ Relationship to child:_____________________**
2. **Name:___________________________________ Relationship to child:_____________________**
3. **Name:___________________________________ Relationship to child:_____________________**

PROVIDERS

_____________ *(INITIALS)* Our providers rotate between offices to allow patients the opportunity to see them at both of our convenient office locations (Scarsdale and Pasadena). Our EMR system allows us to access your file from either location. Please make an appointment to see a specific provider. We cannot guarantee your preferred provider will be available if you walk in.

NOTICE REGARDING RESULTS/REFERRALS

_____________ *(INITIALS)* If you have not heard from our staff concerning your Lab/X-ray results or referral, I understand I share responsibility with the office to obtain the information. Please contact our office if you have not received a call within 7 business days.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize NCNPC or Dr. Rivera to release information as needed to process my claim.

_______________________________ _______________________________ _______________

Parent Name *Parent Signature* *Date*