Harlingen Pediatrics Associates - Patient Registration

Patient Name: _____
Last First Middle Suffix

DOB: ____/____/____ Gender: ____ Patient's SS#: _____-___-_____ Phone (H) (____) _____-_____

Please fill in or circle one of the following that applies.

Child lives with: Mother, Father, or other_____. Ethnicity: Not Hispanic or Hispanic
How would you like to be contacted: Phone, Mail, or E-Mail. Primary Language _____.
Race: American Indian or Alaska Nat., Asian, Black or African American, Nat. Hawaiian or other Pacific Isl., White, or Other Race.

Father/Guardian

Name: _____
Last First Middle Suffix

DOB: ____/____/____ Marital Status: _____ SS#: _____/____/_____

Address: _____ _____ _____ _____
Mailing Zip Code City State

Home Phone (____) _____-_____ Work Phone (____) _____-_____ Ext. _____ Cell (____) _____-_____

Employer: _____ E-Mail Address: _____

Mother/Guardian

Name: _____
Last First Middle Suffix

DOB: ____/____/____ Marital Status: _____ SS#: _____-___-_____

Address: _____ _____ _____ _____
Mailing Zip Code City State

Home Phone (____) _____-_____ Work Phone (____) _____-_____Ext._____Cell (____) _____-_____

Employer: _____ E-Mail Address: _____

Additional Children

Name: _____ **DOB:** ____/____/____
Last First Middle MM DD YY

Name: _____ **DOB:** ____/____/____
Last First Middle MM DD YY

Name: _____ **DOB:** ____/____/____
Last First Middle MM DD YY

In case of Emergency Notify: _____ Phone (____) _____-_____ Relationship _____

In case of my absence, I authorize _____ to care for my child/children.
(Other than Parent)

Phone (____) _____-_____ Relationship _____

It is very important on each visit that you present your current insurance card. Please review the list of insurance carriers that we accept. The list is posted in the front reception area of the office. Our office will make every attempt possible to file your visits correctly. Please let us know as soon as possible if your insurance has changed. A statement will be sent to you if there is a balance that was not covered by your carrier.

If you have no insurance coverage or if your insurance is not listed as one of the company's that we file for, all professional services rendered are charged to the patient. You are required to pay services rendered at the time of the visit. Unless other arrangements have been made. The guarantor will be given the necessary forms at the time of the office visit to expedite your reimburesment. We do not wait for payment from your insurance company if you fail to keep your agreement to pay, your account may possibly be forwarded to a collection agency.

In case of hospital treatment, I authorize payment of medical benefits to undersign physician or supplier for services. I understand and agree if my insurance does not cover or if I have no coverage, I will be responsible for the charges incurred. I certify this information is true and correct to the best of my knowledge.

I UNDERSTAND, IF I REQUEST TO TRANSFER MEDICAL RECORDS TO ANOTHER PROVIDER, I WILL NO LONGER BE SEEN AS A PATIENT WITH HPA.

X_____ ____/____/_____
Parent/Legal Guardian Signature Date

Patient Name_____

DOB_____

Advanced Practice Nurse
Consent for Treatment

This facility has on staff an advanced practice nurse to assist in the delivery of medical pediatric care.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

Print Name_____ Date_____

Signature_____