Visit ID					
New Est	CP	RN			

Patient Registration

Today's Date: _____ Time: _____

Patient #1	Patient #2
Patient's Name: _____	**Patient's Name: _____**
Date of Birth: _____ Patient's Age: _____	**Date of Birth: _____ Patient's Age: _____**
Patient's Gender: M / F	**Patient's Gender: M / F**
Reason for today's visit:_____	**Reason for today's visit:_____**
_____	_____
_____	_____

Guardian's Name: _____ **Relationship to Patient: _____**

Guardian's Address: _____
Street **City** **State** **Zip**

Best Phone #: _____ **Alternate Phone #: _____**

Email: _____ **Primary Physician: _____**
(for 48 hour patient follow-up by our nurses)

Insurance Company: _____

Policy Holder Name: _____ **Policy Holder Date of Birth:_____**

Relationship to Patient: _____ **Policy Holder SSN:_____**

Preferred Pharmacy: _____ **Location:_____**

Acceptance of Consent Statements:

_____I acknowledge receiving the **Little Star Pediatric Urgent Care's Financial Policy** and **Notice of Privacy Practices** (the Notice). The Notice explains how Little Star Pediatric Urgent Care may use and disclose your protected health information for treatment, payment and healthcare operations purposes.

_____I am the parent or guardian of the above named patient, and I have the legal right to **consent to medical and surgical treatment** for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that Little Star Pediatric Urgent Care and his/her designated associates or assistants believe are necessary for this child. I understand that by signing this form I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

_____**Consent to Release and Obtain Information**: In agreement with federal and state law, I agree to allow Little Star Pediatric Urgent Care to deliver the necessary care to this child in order to provide continuity of care and treatment. Little Star Pediatric Urgent Care and/or the patient's provider may obtain form any source and examine and use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments, any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This request to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

_____**Electronic Prescriptions**: I voluntarily authorize Little Star Pediatric Urgent Care to allow electronic prescribing for the patient's mail order prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this clinic, or until I withdraw my consent.

_____ _____
Signature of Patient/Responsible party **Date (m/d/y)**