(Please use black ink only)

ISLAND COAST PEDIATRICS

Florida Drug Free Workplace

CHART#_____

REGISTRATION & ACKNOWLEDGMENT FORM

Patient's Name: _____ Sex: __ DOB: __/__/__
First MI Last

Guarantor (Who's responsible for the bill?): _____
First MI Last DOB

Mailing Address: _____
Street City State Zip Guarantor's Home #

Child's Physical Address (if different): _____
Street City State Zip

Contact E-Mail Address: _____ Home # (Where child lives.): _____

Child's SS #: _____ Parent Emergency Contact #: ( )_____

Primary Ins. Company's Name: _____ Policy Holder: _____

Secondary Ins. Company's Name: _____ Policy Holder: _____

Father's Name: _____ SS #: _____ Father's DOB: __/__/__

Father's Work Place: _____ Father's Work Ph. #: _____ Cell/Pager #: _____

Mother's Name: _____ SS #: _____ Mother's DOB: __/__/__

Mother's Work Place: _____ Mother's Work Ph. #: _____ Cell/Pager #: _____

Note: If you wish to restrict who is allowed access to your child's private health information, you must fill out a Request of Limitations & Restrictions form. (To restrict access from a legal parent, you must supply custody documentation.)

How were you referred to us? _____ Child's Last Physician _____

Emergency Contact (Other than parent): #1 _____ #2 _____
Name/Phone Name/Phone

MEMBERS LIVING IN HOUSEHOLD OTHER THAN PARENTS

NAME/DOB/RELATIONSHIP	NAME/DOB/RELATIONSHIP
1.	4.
2.	5.
3.	6.

Does your insurance plan cover vaccines or well care? ❑ Yes ❑ No ❑ Don't Know

Authorization To Treat: The undersigned patient and/or responsible person or relative hereby consent(s) to authorize Island Coast Pediatrics and affiliated physicians and allied health personnel, to administer and perform all medical examination(s) and treatment(s) diagnosed and surgical procedures that may now, or during the course of the patient's care be deemed advisable and/or necessary. I also authorize assignment for payments to Island Coast Pediatrics. I authorize the release of all records to process insurance claims, or to any physicians my child may be referred to. We are not responsible for the safety of children left unattended in our waiting room and our staff accept no responsibility for monitoring their activity. **I have been given a copy of Island Coast Pediatrics' Patient Information Brochure and agree to abide by them. I acknowledge receipt of Island Coast Pediatrics' Notice of Privacy Policy.**

Guardian Signature: _____ Witnessed by: _____

Relationship to Patient: _____ Date: _____