OAK Pediatrics Registration form

Patients name: _____ DOB Month: _____Day: ___Year: _____

Circle: Male Female

Home number: _____ Cell phone: _____

Home address: _____

City: _____ State: _____ zip code: _____

Email address: _____

Parent/Guardian name: _____ Phone number: _____

DOB Month: _____Day: ___Year: _____

Parent/Guardian name: _____ Phone number: _____

DOB Month: _____Day: ___Year: _____

In case of emergency name: _____ Phone number: _____

Relationship to patient: _____

Primary Insurance name: _____ Subscriber ID _____

Insurance Subscriber name: _____ DOB Month: ___Day: ___Year: _____

Secondary Insurance name: _____ Subscriber ID: _____

Insurance Subscriber name: _____ DOB: _____

Pharmacy Name: _____ City: _____ Phone number: _____

AUTHORIZATION FOR MEDICAL INFORMATION & PAYMENT OF MEDICAL BENEFITS

➢ I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MEDICAL CLAIM FOR SERVICES PROVIDED BY THE PHYSICIAN.

➢ I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES PROVIDED.

➢ I AGREE THAT OAK PEDIATRICS CAN REQUEST AND USE MY PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS AND/OR PHARMACY NETWORKS FOR TREATMENT PURPOSES.

➢ I AUTHORIZE THE SHARING OF MY MEDICAL RECORDS WITH MY OTHER PROVIDERS THROUGH THE HEALTH INFORMATION EXCHANGE (HIE). I UNDERSTAND THAT DETAILED INFORMATION REGARDING HIE IS AVAILABLE UPON MY REQUEST, AND I MAY OPT-OUT AT ANY TIME.

Acknowledgement of Office Policies & Notices Additional copies available upon request; Please speak with the front office for details.

➢ I acknowledge having received a copy of the Following Notices with my New Patient Welcome Packet:

➢ Health Information Exchange Consent Notice (HIE) (secure computer networks that allow participating health care and insurance providers nationwide to access healthcare information to enhance coordinate of care) to disclose information to other healthcare organizations or providers. I understand that I have a right to request and receive an accounting of disclosures of access to my information through the HIE at any time.

➢ Preventative Visit Billing / Preventative Lab Billing Policy

➢ Notice of Privacy Practices

➢ Financial Policy

➢ Referral Policy

Print name of person completing this form: _____ Relationship: _____

Signature: _____ Date: _____