Patient Registration *(Pediatric)*

Decerina UY MD, P.C.
649 Route 25A
Rocky Point, NY 11778

Patient Information

Date _____ Chart No. _____

Patient _____ Sex: ☐M ☐F DoB__/__/__ SS# _____

Mother/Guardian _____ DoB__/__/__ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Father/Guardian _____ DoB__/__/__ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Sibling _____ Sex: ☐M ☐F DoB__/__/__ SS# _____

Sibling _____ Sex: ☐M ☐F DoB__/__/__ SS# _____

Sibling _____ Sex: ☐M ☐F DoB__/__/__ SS# _____

Children live with: ☐ Mother ☐ Father ☐ Guardian _____

Emergency Contact Person _____ Relation _____ Phone _____

Party Responsible for Payment of Medical Services: ☐ Father ☐ Mother ☐ Guardian ☐ Both _____

How did you hear about our practice? ☐ Referral _____

☐ Friend/Family ☐ Phone Directory ☐ Internet ☐ Newspaper ☐ Magazine ☐ Other _____

Insurance Information

Primary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Secondary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Name of Insured _____ DoB__/__/__ Relation _____

Medicaid/Champus/Other _____ Current Card # _____

Physician Listed on Card _____ Phone _____

Authorization of Treatment and Assignment of Benefit

I authorize **DECERINA UY, M.D.** to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to **DECERINA UY, M.D.** for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: _____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature _____ Relationship _____ Date _____

Witness' signature _____ Date _____

☐ I prefer to do my own insurance filing. Signed _____ Date _____

HIPPA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.

Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

Name_____
Phone_____
Name_____
Phone_____

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

Name_____
Phone_____
Name_____
Phone_____

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

_____
_____
_____

- Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number.

_____
_____
_____
_____

Please be aware that a cell phone is not a secure and private line.

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL". ☐ Yes ☐ No

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No

_____
PATIENT NAME *print* (Parent / Guardian, if under 18 years)

_____ Date _____
PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Notes