Chart# ____________

Black & Benton Pediatrics

18 Year Old and Up Patient Registration Form

Patient Information

Last Name: ____________________

First Name: ____________________ MI: ____

DOB: ____________ SS#: ____________

Phone Number: ____________________

Sex: □ Male □ Female Hispanic: □ Y or □ N Race: ____

Patient Address: ____________________

City: ____________ State: ______ Zip: ______

Patient lives with: □ Mother □ Father □ both □Other________

Mother/Guardian's Information

Last Name: ____________________

First Name: ____________________ MI: ____

Street Address (If different from above):

____

City: ____________ State: ______ Zip: ______

Primary Phone #: ____________________

SS#: ____________ DOB: ____________

Marital Status (Please check one): □Single □Married □Divorced □Separated □Widowed

Occupation: ____________________

Name of Employer: ____________________

Father/Guardian's Information

Last Name: ____________________

First Name: ____________________ MI: ____

Street Address (If different from above):

____

City: ____________ State: ______ Zip: ______

Primary Phone #: ____________________

SS#: ____________ DOB: ____________

Marital Status (Please check one): □Single □Married □Divorced □Separated □Widowed

Occupation: ____________________

Name of Employer: ____________________

18 Year Old & Up Please Read & Sign

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or inquire about appointment status without my specific written permission. Black and Benton Pediatrics will not release medical information to my parents without my written authorization in accordance with this document.

_____**I DO NOT** grant access to my parents and/or guardians. No medical information, records, or appointment status information can be discussed or released.

_____**I WISH TO** grant the following individuals access to my healthcare providers and/or medical information:

1) Name: ____________________
   Relationship: ____________________
2) Name: ____________________
   Relationship: ____________________

Patient Signature

____

Emergency Contact

Please list a friend/relative that does not live with you.

Name: ____________________

Primary Phone #: ____________________

Primary Insurance Information

Name of Company: ____________________

Policy Holder: ____________________

DOB: ____________ ID#: ____________

Secondary Insurance Information

Name of Company: ____________________

Policy Holder: ____________________

DOB: ____________ ID#: ____________

Pharmacy Information:

Name: ____________________

Phone #: ____________________