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 Race: ___________ Hispanic: □ Y or □ N

Patient Address: ___________________________________

City: _____________________ State: _______ Zip: _________

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

Mother/Guardian's Information

Last Name: ____

First Name: ________________________________ MI: ____

Street Address:

____

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:

____

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 Insurance: ________________________________

Policy Holder: _________________ DOB:_____________

ID#: ________________ Group#: _________________

Secondary Insurance Information

Name of Insurance: ________________________________

Policy Holder: _________________ DOB:_____________

ID#: ________________ Group#: _________________

Pharmacy Information:

Name: ____

Phone Number: _____________________________________