BERNSTEIN PEDIATRICS

PATIENT REGISTRATION FORM

2121 E. FLAMINGO RD #100

LeRoy Bernstein, M.D.

LAS VEGAS, NV
89119

Patient's Name: ________________________ Patient's Date Birth: _____/_____/_____

Patient's Home Address: ________________________________

City/State: ________________________ Zip Code:____________

Home Phone Number: (__________) ____________ Female ☐ Male ☐

Social Security # _ _ _ - _ _ - _ _ _ _ Grade:________ School: __________

Patient lives with: ▪Both Parents ▪Mother ▪Father ▪ Step Mother/Father:__________________
Legal Guardian: ______________

*Parental Information, Legally determined **BY LAW** must provide proper documents and current photo I.D.*

Mother/Guardian Information

Last Name, First Name: ____________________
Date of Birth: ____/___/____ SSN: _ _ _ - _ _ - _ _ _ _
Home Address: ____________________
City: State: Zip: ____________________
Employer: ____________________
Occupation: ____________________
Daytime Phone (__) ____-______ Cell (__) ___-______

Father/Guardian Information

Last Name, First Name: ____________________
Date of Birth: ____/___/_____ SSN: _ _ _ - _ _ - _ _ _ _
Home Address: ____________________
City: State: Zip: ____________________
Employer: ____________________
Occupation: ____________________
Daytime Phone (__) ___-_____ Cell (__) ____-_____

Who has legal custody? ☐ Mother ☐ Father ☐ BOTH ☐ OTHER: ____________________

Insurance billing statement mailed to: Mother Father

Every effort is made to protect our patients' privacy. However, in the case of an emergency in which a parent/legal guardian cannot be reached, we may need to call someone on your child's behalf. Please list below the name of someone we have your permission to contact if necessary.

Emergency Contact: ________________________ **Phone Number:** ( ) ____________

Relationship to child: ________________________

INSURANCE INFORMATION:

Name of Insurance Company: ________________________________
Insurance Subscriber Name: ____________________Social Security #: _____ _____ _____
(Name of person who carries the insurance)
DOB _____/____/_______ Group No: ___________ ID No: ________________

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How did you hear about us? ☐ Phonebook ☐ Insurance Co. ☐ Friend/OTHER: ______________

Previous Medical Care: ________________________________
Phone Number: ( ) ________________ Fax Number: ( ) ________________

SIBLINGS:

Name: __________________ DOB: _________ / _________ / __________ ☐ Male ☐ Female
Name: __________________ DOB: _________ / _________ / __________ ☐ Male ☐ Female
Name: __________________ DOB: _________ / _________ / __________ ☐ Male ☐ Female

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MEDICATIONS: Please be sure to indicate strength/dosage/duration.

- ____________________ ____________________ ____________________
- ____________________ ____________________ ____________________
- ____________________ ____________________ ____________________

LIST ALL PATIENT ALLERGIES TO MEDICATIONS/FOODS/ENVIRONMENT:

- ____________________ ____________________ ____________________
- ____________________ ____________________ ____________________
- ____________________ ____________________ ____________________

Family History: Chronic or existing diseases or medical problems (e.g. asthma, diabetes, epilepsy)

____ ____

____ ____

____ ____

Please read and initial the following policy statements. Initialing indicates that you have read each policy statement.

______ ***MEDICAL RECORDS***
(Initial) Bernstein Pediatrics will be happy to give you a copy of any and all medical records for your child with at least a 24-48 hour notice, there is a .60 cents per page fee.

______ ***CANCELLING APPOINTMENTS***
(Initial) We require your cancellation/rescheduled notice no later than 24 hours prior to your scheduled appointment. If notice is not received 24 hours prior to your scheduled appointment there will be a charge of $25 non-cancellation fee.

______ ***ANNUAL WELLNESS EXAMS***
(Initial) Annual wellness exams for your child may or may not be a covered benefit of your health plan including hearing and vision screening. Please review your plan's evidence of Coverage for specific covered benefits or call your health plan directly for this information. If an annual wellness exam is a covered benefit, please confirm whether your child may be seen ***once*** per calendar year **OR 365 days from the date of last examination**. Our office is not responsible for monitoring the length of time between wellness examinations.

CONSENT

The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to Bernstein Pediatrics (Dr. LeRoy Bernstein). I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Practice and/or the insurance company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

Parent Signature:____

Print Name: ____ **Date:**____________________

Consent for Medical Treatment of a Minor Child

I, (We), ___________________________________ and____
(name) (name)

of _______________________________, ________________________, ______________________ do hereby
(city) (county) (state)

state that I am (we are) the parent(s) or legal guardian (s) of:____
(name)

____, a minor, age _____________________________,
(name)

born on ____ who resides with me (us) at
(date)

____
(street address, city, state)

I (we) authorize __________________________ _________________________ ___________________________
(name) (name) (name)

an adult over 18 years of age, who resides at____
(address)

in the city of _____________________________________, state of _____________________________________
(city) (state)

to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state(s) of Nevada.

for the period from _____________,_________ to ________________,_________

Dated this ____________ day of ____________________,___________.

Signature(s) of parent(s) or guardians(s):

____
Signature(s) of parent(s) or guardian(s)

Witness:_________________________________ Witness:____