

Cinco Ranch Pediatrics Registration

Child's Name: _____ M / F Birthday: _____
Child's Name: _____ M / F Birthday: _____
Child's Name: _____ M / F Birthday: _____

Parent Information (Please indicate all parents/step-parents with legal authority to consent to care):

Name: _____ Birthday: _____
Relationship (please circle): Mother Father Stepmother Stepfather
Address: _____ City and ZIP: _____
SSN _____ Home Phone _____
Work Phone: _____ Mobile: _____
Employer: _____

Name: _____ Birthday: _____
Relationship (please circle): Mother Father Stepmother Stepfather
Address: _____ City and ZIP: _____
SSN _____ Home Phone _____
Work Phone: _____ Mobile: _____
Employer: _____

Who is the primary insurance holder? _____

Who is financially responsible for the child? _____

CONSENT FOR TREATMENT (Please initial next to each paragraph)

_____ I consent to services, treatment, and diagnostic procedures for my child(ren) listed above, including but not limited to medications, vaccinations, lab tests, and other studies which may be ordered by the physicians of Cinco Ranch Pediatrics.

_____ I acknowledge receiving the CRP Notice of Privacy Practices. The Notice explains how CRP may use and disclose my protected health information for treatment, payment and health care operations purpose.

_____ I acknowledge that I am responsible for notifying CRP in writing of any changes to my child's legal guardians, including issues pertaining to re-marriage, divorce, separation, or custody agreements that limit the rights of any party.

_____ My signature acknowledges that I have the right to ask questions and receive information about the services and I voluntarily sign this consent. This authorization shall remain valid unless I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Signature of Legal Guardian

Date