

# Lakelands Family Practice & Pediatrics- Pediatric Patient Registration Form

A member of Carolina Health Centers Inc.

**Patient's Demographic information**

**PT Acct #** \_\_\_\_\_

Patient's Name: _____			Birthday: _____		
First	Middle	Last	Month, Day, Year		
What is the best contact # to leave messages about appointments, lab results, etc?					
Name		#	Relationship		
Patient's Social Security #: _____			Sex: <b>Male</b> <b>Female</b> <b>Other</b>		
Address: _____					
		City, State	Zip	County	
School/ Daycare: _____					

**Race/Ethnicity/ SOGI/ Language**

Race: <b>Black/ African American</b> <b>Asian</b> <b>American Indian/Pacific Islander</b> <b>White</b>					
Ethnicity: <b>Hispanic</b> <b>Non-Hispanic</b> <b>Unknown</b>					
Gender Identity: <b>Male</b> <b>Female</b> <b>Transgender Female (M to F)</b> <b>Transgender Male (F toM)</b>					
Choose Not to Disclose		Non-binary/genderqueer		Questioning	
Preferred Pronoun: <b>He/ Him</b>		<b>She/Her</b>	<b>We/Them</b>		
Sexual Orientation: <b>Lesbian/Gay</b>		<b>Straight</b>	<b>Bisexual</b>	<b>Something Else</b>	
Don't Know		Choose Not To Disclose			
Homeless: <b>Yes</b> <b>No</b>					
Primary Language: <b>English</b> <b>Spanish</b> <b>Other:</b> _____					
Are there any impairments or communication barriers that we need to be aware of?					
_____					

**Parents/Guardians this section is YOUR information**

Parent 1: _____		
Cell#: _____	Work # _____	
Email: _____	Social Security # _____	
Address: _____		
How do you prefer to be contacted? (please circle one) <b>CALL</b> <b>TEXT</b> <b>EMAIL</b>		
Parent 2: _____		
Cell#: _____	Work # _____	
Email: _____	Social Security # _____	
Address: _____		
How do you prefer to be contacted? (please circle one) <b>CALL</b> <b>TEXT</b> <b>EMAIL</b>		

In case of an emergency who should we contact?

Name	Number	Relationship
------	--------	--------------

**Patient's Insurance Information**

If your child is covered by Medicaid which plan are they covered by? (circle the plan that applies)	
<b>Select Health</b>	<b>Molina WellCare Absolute Total Care Healthy Blue</b>
Insurance ID # _____	
When did this plan become active coverage for your child? _____	
If your child has private insurance coverage which plan covers them? (circle or list below)	
<b>BCBS</b>	<b>Cigna Other:</b>
Insurance ID or group # _____	
When did this plan become active coverage? _____	
Who is the primary card holder: _____	
	Relationship to Patient
Cardholders Date of Birth: _____	Sex: <b>Male Female</b>
Does your child have a secondary insurance coverage? <b>YES NO</b>	
If yes, what plan is the secondary coverage? _____	
Secondary Coverage ID or group # _____	
When did the secondary coverage become active? _____	
Who is the primary card holder? _____	
	Relationship to Patient
Cardholders Date of Birth: _____	Sex: <b>Male Female</b>

**Sliding Fee Scale Information:** We are required to charge for all services. However, charges may be adjusted according to your income and the number of family members that reside in the home.

<input type="checkbox"/>	<b>Yes-</b> I would like an application for the sliding fee scale.
<input type="checkbox"/>	<b>No-</b> I do not wish to apply for the sliding fee scale at this time.

How many members reside in the home? \_\_\_\_\_  
Annual Household Income? \_\_\_\_\_  
Homeless: **YES NO**

**HIPAA**

I understand and comply with Carolina Health Centers, Inc copy of its Privacy Notice, which explains how my child's health information will be handled in various situations.

**I also choose to disclose my child's information to the following individuals:**

Name: _____	Contact #: _____
Name: _____	Contact #: _____
Name: _____	Contact #: _____

\_\_\_\_\_  
**Signatures of Parent or Patient's who are 16 and older** **Date**