



3500 5th Avenue, Suite 101
 San Diego, CA 92103
 Tel: (619) 295-3911
 Fax: (619) 295-4356

Patient Registration Form

Patient's Full Legal Name (Please list all children)	Preferred Name or Nickname	Date of Birth	Sex
1.			
2.			
3.			
4.			
5.			
6.			

Street Address _____
 City _____ State _____ ZIP _____
 Preferred Phone _____ Preferred Email _____
 Pharmacy _____ Pharmacy Phone _____

Parent/Guardian Information

Parent Name _____ Date of Birth _____
 Relationship to patient _____
 Address (if different from above) _____
 City _____ State _____ ZIP _____
 Preferred Phone _____ Alternate Phone _____
 Email _____ Employer _____
 Parent Name _____ Date of Birth _____
 Relationship to patient _____
 Address (if different from above) _____
 City _____ State _____ ZIP _____
 Preferred Phone _____ Alternate Phone _____
 Email _____ Employer _____

Insurance Information

Primary Insurance Company _____ Policy Number _____
 Subscriber _____ Subscriber Date of Birth _____
 Subscriber SSN (Needed for Tricare Insurance Only) _____
 Secondary Insurance Company (if applicable) _____ Policy Number _____
 Subscriber _____ Subscriber Date of Birth _____

Preferred method of communication for appointment reminders and recalls (check one)

___ Text to number _____
 ___ Email _____
 ___ Call to number _____



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Consent to Treat

I give permission for San Diego Uptown Pediatrics Medical Group to treat my minor child(ren) named above. In the event of an emergency and I cannot be contacted, I give my permission to San Diego Uptown Pediatrics Medical Group to treat my minor child as required by the events of that emergency situation.

I consent to my physician obtaining information from other treating physicians, laboratory and radiology results, medication prescribed elsewhere, and other information deemed necessary to provide appropriate care.

In my absence, I give the following persons permission to consent to medical treatment, including any necessary examinations, tests, and immunizations. Please list name(s) and relationship to the patient.

Financial Policy

By signing this form, I understand that I am financially responsible for all professional charges that my child may incur. A medical insurance card is required at every office visit. I hereby authorize payment of medical benefits by my medical insurance company direct to San Diego Uptown Pediatrics Medical Group. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that I am responsible for paying any co-payments, deductibles and other fees not covered by my insurance carrier. I understand that I may be responsible for charges incurred if I do not provide accurate insurance information at the time of my child's visit. I authorize San Diego Uptown Pediatrics to release any information acquired in the course of my treatment necessary to process insurance claims.

I am aware that San Diego Uptown Pediatrics is not contracted with Medi-Cal, and if my child is insured under Medi-Cal they are required to be treated by a contracted physician.

HIPAA (Health Insurance Portability and Accountability Act)

I have read the HIPAA Notice of Privacy Practices for San Diego Uptown Pediatrics Medical Group. I am aware that a copy is available on the practice web site and that I may request a hard copy at any time.

Open Payments Database

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

Acknowledgement and Signature

I confirm that the information on this form is current and accurate. I agree with the office policies outlined above.

Signature _____ Date _____

Name (printed) _____ Relationship to Patient _____