

CHRISTAKIS PEDIATRICS

Patient Enrollment Form

Welcome to our practice! Please clearly PRINT out the information requested. Thank you.

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: ___ - _____ SSN if avail: _____

Whom may we thank for referring you to our practice? _____

Mother's Name (guardian): _____ Date of Birth: _____

Address/City/State/Zip: _____

Home Phone: () _____ Work phone: () _____ Cell() _____

Mother's Occupation/Employer: _____ SSN _____

Father's Name (guardian) _____ Date of Birth: _____

Father's Occupation/Employer: _____ SSN _____

_____ Check here if father has same address and phone numbers. If different, please continue.

Father's Address/City/State/Zip: _____

Home Phone: () _____ Work phone: () _____ Cell() _____

Name of Insurance/Policy Number: _____

Name of Primary Insured/Cardholder: _____

Information Release/Consent to Treat/Payment Responsibility

I hereby authorize:

- 1. Dr Paul Christakis to release any information concerning the patient to any health care professional or medical facility, necessary for coordination of care.**
- 2. Any health care professional or facility to release all information concerning the patient to Dr Paul Christakis, necessary for coordination of care.**
- 3. Dr Paul Christakis to release any information necessary for the processing of insurance claims for services provided.**
- 4. Dr Paul Christakis or any medical professional filling in for Dr Christakis to examine and treat the above-named child.**
- 5. Dr Paul Christakis to respond to any non-urgent medical queries by non-encrypted (non-secure) email, and I understand that email is not to be used in any case to communicate with our office in an emergency (instead, calling 911) or for other urgent or sensitive matters (instead, calling our office directly.)**

I accept responsibility for payments including balances, copays, deductible and the \$250 annual practice/information fee, to be made directly to Christakis Pediatrics, PA.

I have read, understand and agree to the financial policies as outlined in the Christakis Pediatrics Financial Policy, available on our website, www.bocachild.com

I agree that a copy of this signed agreement will be as valid as the original.

The information I have provided on this form is true and correct to the best of my knowledge.

Signature: _____ Relation to Patient: _____