NIGHTLIGHT PEDIATRIC URGENT CARE PATIENT REGISTRATION

Patient's Last Name _____ **First Name**_____ **Middle Name**_____

Date of Birth:_____/_____/_____ **Gender : M ( ) F ( )**
Patient's Last Name _____ **First Name**_____ **Middle Name**_____

Date of Birth:_____ /_____/_____ **Gender: M ( ) F ( )**
Patient's Last Name _____ **First Name**_____ **Middle Name**_____

Date of Birth:____/_____/_____ **Gender: M ( ) F ( )**

Address_____ **Apt#**_____
City _____ **State**_____ **Zip** _____

PLEASE CHECK ONE: ***Confidential Email*** ☐ Gives you access to your child's records (school notes, Summary of Visit)/
Home Email ☐ Gives you access to the Newsletter **ONLY**

Email Address_____

How did you hear about us ?

o **School Nurse**	o **Search Engine**	o **Drive By**
o **Urgent Care**	o **Social Media (Facebook,Twitter,etc)**	o **Magazine**
o **Family/Friend**	o **Houston Galleria Ad/ Event**	o **Physician**
o **Insurance**	o **Movie Theater Ad**	o **Waze Ads**
o **Mobile Billboards**	o **Community Event (please specify)**	o **Texas Black Expo Event**
	o **Houston Children's Festival**	o **Daycare**

Chief Complaint/Reason for Visit? _____

Pediatrician's Name: _____ **Pediatrician's Phone Number** _____

Race: (circle one) American Indian/Alaska Native Asian Black/African American White Native Hawaiian/Other Pacific Islander

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino

Mother's Name_____ **DOB**_____

Home Phone_____ **Work Phone**_____ ext _____**Cell**_____

Employer _____

Father's Name_____ **DOB**_____

Home Phone_____ **Work Phone** _____ ext _____ **Cell**_____

Employer _____

Mother's or Father's Address (if different from above)_____

City_____ State _____ Zip_____

Primary Insurance:
Policy Holder's Name _____ Policy Holder's DOB_____

Name of your current insurance_____
Secondary Insurance:
Policy Holder's Name _____ Policy Holder's DOB_____

Name of your current insurance _____

Pharmacy Name: _____

Address or Cross Street: _____ **Phone** _____

NIGHTLIGHT PEDIATRIC URGENT CONSENT AND SIGNATURE

PATIENT NAME: _____

PATIENT NAME: _____

CONSENT TO TREAT

I have the legal right and responsibility to obtain and consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Nightlight Pediatric Urgent Care Providers believe are necessary for this child. I understand that by signing this form, and by bringing this child to this medical office for care, I am giving permission to the doctors and other health care providers in this office to provide treatment to this patient as long as he/she is a patient of this practice.

DELEGATION OF CONSENT
(This section is OPTIONAL. Include adults other than parents/legal guardians)

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the State of Texas. This consent includes medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw this delegation of consent.

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge receiving the Nightlight Pediatric Urgent Care Notice of Privacy Practices ("Notice"). The Notice explains how Nightlight Pediatrics may use and disclose your child's protected health information for treatment, payment, and health care operations purposes. "Protected health information" means y child's personal health information found in his/her medical and/or billing records. Your signature below only acknowledges that you have RECEIVED the Notice. If you have questions about the Notice, please contact the Privacy Officer for the office.

GUARANTOR'S STATEMENT OF RESPONSIBILITY

I have received a copy of the Nightlight Pediatric Urgent Care's Financial Policy and understand that I am persona responsible for the payment of this patient's account.

SIGNATURE ACKNOWLEDGES I RECEIVED AND UNDERSTAND THE STATEMENTS ABOVE.

_____	_____
GUARANTOR'S SIGNATURE	**DATE**
_____	_____
GUARANTOR'S PRINTED NAME	**RELATIONSHIP TO PATIENT**