NIGHTLIGHT PEDIATRIC URGENT CARE PATIENT REGISTRATION

Today's Date _____ Preferred language_____

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 _____

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

Chief Complaint/Reason for Visit?_____

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

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_____

(Please Circle) Home/Newsletter (I want pediatric insight to keep my kid's healthy) or Confidential (I want to receive documents about my child)
Email Address_____

How did you learn about our practice (check all that apply)

- o School Nurse
- o Urgent Care
- o Family/Friend
- o Insurance
- o Mobile Billboards
- o Search Engine
- o Social Media (Facebook,Twitter,etc)
- o Houston Galleria Ad/ Event
- o Movie Theater Ad
- o Event (please specify) _____
- o Drive By
- o Magazine
- o Physician
- o Waze Ads
- o Kids Directory
- o Daycare

NIGHTLIGHT PEDIATRIC URGENT
CONSENT AND SIGNATURE

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 provid 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