Kansas City Pediatric Cardiology

PATIENT REGISTRATION FORM

First Name	Middle Intl	Last Name	Nickname

Birth Date:____________________ Male______ Female ______ Primary Care Physician____________________________

Race: ______________________________ Hispanic or Latino: Y or N Primary Language: ____________________

Primary Phone:( )______________________________Secondary Phone:( )______________________________

Address____

City ____________________________________State ____________ Zip _____________________

Status of Parents: Married ☐ Seperated ☐ Divorced ☐ Widowed ☐ Unmarried ☐

Mother or Guardian Information

____Primary Phone ( )____________________________

Last Name First Name

RELATIONSHIP TO PATIENT(S): ☐ Mother ☐ Step-Mother ☐ Grandparent ☐ Foster Parent ☐ Other__________________

Email Address:________________________________ SSN#________________________DOB:________________

Address:____________________________________ City: __________________ State: ________ Zip: _____________

Employer:____ Work Phone: ( )_________________________________

Father or Guardian Information

____Primary Phone ( )____________________________

Last Name First Name

RELATIONSHIP TO PATIENT(S): ☐ Father ☐ Step-Father ☐ Grandparent ☐ Foster Parent ☐ Other ___________________

Email Address:________________________________ SSN#________________________DOB:________________

Address:____________________________________City: __________________ State: ________ Zip: _____________

Employer:____ Work Phone:( )_____________________________

WITH WHOM DOES THE CHILD RESIDE? ☐Father ☐ Mother ☐ Legal Guardian ☐ Step Parent ☐ Foster Parent ☐Other_____________
If child/children are living with step parent or other relative, please complete the following:
Name:______________________________ DOB:______________ Phone#( )________________________

Primary Health Insurance:	Secondary Health Insurance:
1) Company Name:____________________________	2) Company Name:____________________________
Policy ID#:____________________________	Policy ID#:____________________________
Subscriber's Name:____________________________	Subscriber's Name:____________________________
Subscriber DOB: ________________________	Subscriber DOB:________________________
RELATIONSHIP TO PATIENT: ☐MOTHER ☐ FATHER	RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER
☐ STEP-PARENT ☐ OTHER:__________________________	☐ STEP-PARENT ☐ OTHER __________________________

I authorize Kansas City Pediatric Cardiology to release any and all medical records, pertaining to my child's health, to my insurance company for any requested additional information. I, ____________________________, hereby acknowledge that Kansas City Pediatric Cardiology Associates has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me/my child may be used and disclosed, and how I can access this information. I also acknowledge that I was provided with Kansas City Pediatric Cardiology Associates financial policy and agree to the policy as stated. I understand that if I have questions or complaints I may contact KCPCA.

Signature____ Date______________________

CONSENT OF TREATMENT

The physicians of Kansas City Pediatric Cardiology have my permission to provide my child/children with any necessary treatment.
The following persons have my permission to seek medical attention for my child/children in my absence.

1)_______________________________ (2)_______________________________ (3)_______________________________

Referring Provider: ____

Parent/Legal Guardian Signature____ Date______________________