18+ PATIENT REGISTRATION

Last Name: _____ First Name: _____ Middle name: _____

Preferred name (if different than legal name)*: _____

Date of Birth: _____ Sex assigned at birth: F / M Preferred pronouns: _____

Ethnicity: Unknown / Hispanic or Latino / Not Hispanic or Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African-American / Native Hawaiian or Other Pacific Islander / White / Decline to specify / Other Race

** Please note that while staff is happy to use your preferred name in the office, patients are listed by legal name in our system and on all medical paperwork. If you wish to update your legal name, please present staff with documentation such as birth certificate, court document, or ID card.*

Patient's mailing address:

_____

(Street or PO Box) (City) (State and Zip)

Patient's contact information:

Phone number: (_____) _____ - _____ Email Address: _____

➔ Receive automatic text reminders to cell phone number listed above? Yes / No

Emergency contacts - please list both name *and* relationship:

1. _____ _____ Phone: (_____) _____ - _____

2. _____ _____ Phone: (_____) _____ - _____

PLEASE NOTE: If you would like to share your medical health information with a third party, such as a parent, you will need to complete our 18+ privacy and release of information form (attached).

Alger Pediatrics 18+ privacy and release of information form

**Please note: this form must be completed and signed by the patient.*

Patient's name: _____ **Patient's date of birth:** _____

I understand and acknowledge that as of my 18th birthday, my parent/guardian will no longer be permitted access to my medical records and information without my specific written permission.

Alger Pediatrics will not release any medical information to my parent/guardian or permit my parent/guardian to schedule appointments without my written consent in accordance with this document.

☐ I do not wish to grant a third party access to my medical information. Alger Pediatrics will share medical information only with me, the patient.

☐ I wish to grant the below person(s) access to some or all of my medical information.

Name: _____

Relationship: _____

Phone number: _____

I wish to grant the person(s) named above access to the following medical information:

☐ All medical information, including all records listed below.

- ☐ Office notes
- ☐ Lab results; pathology reports
- ☐ X-rays
- ☐ Financial history report
- ☐ Nursing home, home health, hospice, and other physician records
- ☐ Mental health records
- ☐ Record of communicable disease testing (including HIV)
- ☐ Alcohol/drug abuse treatment
- ☐ Only share the following information:

  _____

This authorization is valid for one year from the date signed, unless an earlier termination date is specified. This authorization may be revoked in writing at any time. Alger Pediatrics does not require this authorization as a condition for the delivery of healthcare or treatment. There is potential that information disclosed in this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA).

Patient signature: _____ **Date signed:** _____