PEDIATRIC CENTER AT RENAISSANCE

FAMILY REGISTRATION FORM

Today's Date___/___/___

CHILD'S NAME (First, Middle, Last)	SEX (circle)	Date Of Birth	Ethnicity	Race	PCP
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ Juan Saenz ☐ Jennifer Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ Juan Saenz ☐ Jennifer Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ Juan Saenz ☐ Jennifer Saenz
	M F		☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		☐ Juan Saenz ☐ Jennifer Saenz

	PARENT/GUARDIAN #1	PARENT/GUARDIAN #2
Name:		
Relationship to patient(s):		
Date of birth:		
Mailing address:		
Primary phone:		
Secondary phone:		
Alt phone:		
Email address:		
Employer:		
Occupation:		
Preferred language:		

Parents are: ☐Single ☐Married ☐Separated ☐ Divorced (if divorced, who is the custodial parent? ☐#1 or ☐#2)

PATIENT CONFIDENTIAL COMMUNICATION PREFERENCE

Consent to Contact for Appointment Reminders and Other Communications

Patients in our practice may be contacted via email, phone and/or text messaging for general information/communications related to Pediatric Center at Renaissance, including:

- Appointment reminders
- Well child check-up appointments
- Situational/seasonal service suggestions (ex. flu shot clinics, asthma follow up, weight checks)

We will send communications via your preferred method of contact. You may revoke this consent at any time.

How would you wish to be contacted? (choose only one)
☐Mailing Address ☐Cell Phone ☐Work Phone ☐Home Phone ☐Email ☐Text Message

By signing below, I consent to receiving this type of communications from Pediatric Center at Renaissance. I understand that this request to receive emails, phone calls and/or text messages will apply to all future communication from the office regarding the information above.

_____ _____

Parent/Guardian Signature Date

Cell phone number that I authorize to receive text messages*:

_____

Phone number that I authorize to receive phone calls and voicemails:

_____

Email address that I authorize to receive emails:

_____

**Pediatric Center at Renaissance does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details). You may opt-out at anytime by sending STOP to 622-622. If you change phone carriers, you will need to opt back in by texting MCALLENSAENZ to 622-622.*

Is it okay to leave a voicemail regarding labs/medical information: ☐ Yes ☐ No

If yes, who is the preferred contact? _____ Preferred Phone #: _____

MEDICAL INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance company:		
Carrier phone #:		
Policy #:		
Group #:		
Policy holder:		
Date of birth:		
Relation to patient:		

Do you have Medicaid insurance? ☐ No ☐ Yes If yes, please complete the table below for any child on a Medicaid plan.

CHILD'S NAME	MEDICAID PLAN	CERTIFICATE NUMBER

Insurance Responsibility Letter to Patients

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you as the patient, to please check with your insurance company prior to any procedures and / or tests. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred here. If your carrier requests other information from you such as evidence of other insurance, they will not provide reimbursement of your claim until you provide the requested information. If you fail to do so, you will be billed for any outstanding charges. Please remember, your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

It is your responsibility to update our clinic when there is a change in your insurance plan. If we cannot find active coverage at the time of service, you will be treated as private pay. Payment is expected up front; however, budget plans are available in the event the balance cannot be paid in full.

CONSENT TO TREAT

Labs/Procedures/Immunizations/ Vaccines/Injectables

I voluntarily authorize and consent to the medical care, treatment, diagnostic tests, transfers, and referrals that the providers at Pediatric Center at Renaissance and their designated associates or assistants believe are necessary. I also consent to the taking of photographs related to the care and treatment of the patient and understand that such photographs may be made part of the medical record. l understand that by signing this form, I am giving permission to the doctors, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

List of Name of Patient(s):

_____

_____

At times you may not be able to bring your child in for treatment. Please specify any other adult 18 years or older that is able to act on your behalf in authorizing medical treatment: (i.e., grandparent, aunt, uncle, etc.). Please check next to the person that you want as the emergency contact in case we are not able to get a hold of either parent/guardian.

Name Address Phone # Relationship

_____

_____

Permission to Treat Patients 16 Through 18 Years Old without Parent/Legal Guardian

Pediatric Center at Renaissance must receive permission, from a child's parent or legal guardian, prior to providing treatment(s) for preventative care, injury, or illness that is non-life threatening. This form provides the legal permission to treat your adolescent child without an adult present.

Patient's Name: _____ Patient's DOB: _____

This form is specific to patients who are at least 16, but not 18 years old. In addition to giving permission to Pediatric Center at Renaissance to assess and treat the aforementioned minor without an adult present, I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

This authorization is valid until otherwise revoked or until date listed _____.

Please note: insurance card(s) and co-pay amounts (if applicable) must be presented at each visit.

Authorized by: _____ Date: _____

(Parent/legal guardian signature)

PATIENT PORTAL REGISTRATION - MY KID'S CHART

You can access your child's medical records on your smartphone, computer, laptop, and/or tablet through Pediatric Center at Renaissance's secure patient portal at https://saenz.pcc.com/portal. You will need an email address in order to register for the portal.

Parent Email: _____

Parent Name: _____

Parent Phone: _____

Patients requested for portal access:

First Name	Last Name	Birthdate

Once your account is created, you will receive an email with a temporary password that is active for 1 week. You will need to sign into the portal in order to complete your account set-up. Be sure to verify that your name appears correctly and that the names of the patients you have requested access to appear on the screen.

Please be aware that when a patient turns 18, the record for that patient automatically becomes private. After the patient is 18, he or she may grant permission to a parent or guardian to have access to the chart by completing and signing a release form. This permission can be revoked at any time at the request of the patient or at the discretion of the physician.

Please note that messages sent through the portal will only be checked during normal business hours Monday-Friday 8am-5pm.

Signature_____ Date_____

I hereby avow that I am the authorized legal guardian for the aforementioned patients and give permission for Pediatric Center at Renaissance to enroll them in the patient portal.

Please allow 48 hours to receive your email from our office containing your temporary password to access the portal.