TIFFANY PEDIATRICS

LIBERTYDOCTORS
ASSURING HEALTHCARE FREEDOM

Patient Registration

First _____ **M.I.**_____ **Last**_____

Preferred Name:_____ **Date of Birth:** _____/_____/_____

SSN: _____ **Sex:** _____**F** _____**M** **Race** _____

Preferred Language: _____ **Ethnicity:** _____**Hispanic/Latino** _____**Not Hispanic/Latino**

Address: _____

City: _____ **State:** _____ **Zip:**_____

Primary Phone #:_____ ____**cell** ____**home** ____**work**

Alternate Phone #:_____ ____**cell** ____**home** ____**work**

Patient Lives With: _____**Both Parents** _____**Mother** _____ **Father** _____ **Other**

If Other, Please Specify: _____ **Safety Plan:** ___**YES** ___**NO**

If divorced, who has legal Custody? _____ **Court Papers:** ___**YES** ___**NO**
Please provide the office with a copy of all legal documents.

School Enrolled In :_____ **Grade:**_____

Email Address: _____
Patient Portal is available for all patients, please ask the front office for your secure username and password.

Preferred Pharmacy: _____ **This will be used to electronically send prescriptions.**
To have access to your Medication History, Liberty Doctors needs your authorization. ___**YES** ___**NO**

INSURANCE INFORMATION

Primary Insurance Co. _____ **Policyholder Name:** _____

Date of Birth: _____/____/_____ **SSN:** _____/____/_____ **Relationship to Patient:** _____

Policy number: _____ **Group number:** _____

Secondary Insurance Co. _____ **Policyholder Name:** _____

Date of Birth: _____/____/_____ **SSN:** _____/____/_____ **Relationship to Patient:** _____

Policy number: _____ **Group number:** _____

____Copy of Insurance Card on File ____Copy of Driver's License

Form is 2-sided, please flip over to complete

Responsible Party for Care & Payment Info (Mandatory for Minors & Patients with legal guardians)

Relationship to Patient_____

First _____ **M.I.**_____ **Last** _____

Date of Birth: _____/_____/_____ **SSN:** _____ **Sex: F M**

Address _____

Phones: Home (_____**)** _____ **Cell** _____ **Work**_____

You may give Liberty Doctors, LLC written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the information below. You may also use this form to give us consent to leave detailed information, such as results for labs, x-ray, prescription refills, and appointment reminders, on your home answering machine, voicemail at work, cell phone, email or with another party you designate.

I authorize Liberty Doctors, LLC DBA Tiffany Pediatrics to disclose my child's Protected Health Information (PHI) to the following individuals:

Name:_____ **Relationship**_____

Phone: _____

Name:_____ **Relationship**_____

Phone: _____

Name:_____ **Relationship**_____

Phone: _____

I authorize Liberty Doctors, LLC DBA Tiffany Pediatrics to communicate my child's Protected Health Information (PHI) to me via the following methods:

_____**Detailed message on my home phone answering machine** **Phone:** _____

_____**Detailed message on my voicemail at work** **Phone:** _____

_____**Detailed message on my cell phone voicemail** **Phone:** _____

_____**Email detailed Medical Information** **Email:** _____

I, _____**hereby acknowledge that I have received the Notice of Privacy Practices for Liberty Doctors.**

Patient/Legal Guardian Signature _____ **Date:** _____

Liberty Doctors Employee Witness Signature _____ **Date:** _____