# Partners In Health Pediatrics

*Healthcare for Future Generation*

**Sonober Umair, MD**
**Board Certified Pediatrics**

For your convenience, print and complete the registration form to expedite new patient registration.

## PATIENT REGISTRATION / INFORMATION

Name: Last _____ First _____ Middle _____

Date of Birth_____ Gender (circle): M / F Social Security#_____

Patient lives with (circle) Parent/ Legal Guardian/ Foster Parent / Other; If other, list_____

Address_____

City _____ State _____ Zip_____

Phone#_____ Cell# _____ Email _____

Allergies No / Yes (please list) _____

Emergency Contact_____Phone_____Relation_____

## PARENT/ GUARDIAN INFORMATION

Mother's Last Name_____

First Name_____

Address_____

_____

DOB _____

Social Security #_____

Home phone # _____

Cell/Beeper#_____

Employer_____

Email_____

Father's Last Name _____

First Name _____

Address_____

_____

DOB _____

Social Security # _____

Home phone# _____

Cell/Beeper#_____

Employer_____

Email_____

## INSURANCE INFORMATION

**PRIMARY**

Insurance Company_____

Policy Holder_____

DOB_____

ID#_____ GRP#_____

Employer_____

**SECONDARY (If Applicable)**

Insurance Company_____

Policy Holder_____

DOB_____

ID#_____ GRP#_____

Employer_____

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## INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked by either me or my insurance company at any time in writing.

I hereby authorize PARTNERS IN HEALTH PEDIATRICS to apply for benefits on my behalf for covered services rendered by or ordered by. I request that payment from my insurance company be made directly to my physician with PARTNERS IN HEALTH PEDIATRICS.

## AUTHORIZATION TO MAIL/CALL/EMAIL

I certify that I understand the privacy risks of mail, phone call and email. I hereby authorize PARTNERS IN HEALTH PEDIATRICS representative or my physician to call, email or mail me with communication regarding my healthcare including but not limited to appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying PARTNERS IN HEALTH PEDIATRICS to that effect in writing

## GENERAL CONSENT FOR TREATMENT

I, _____Parent or legal guardian of _____, do hereby, consent to any medical care and treatment by Sonober Umair, MD and/or affiliated/ covering provider for the benefit of my child while said child is under the care of PARTNERS IN HEALTH PEDIATRICS.

I certify that the above information is true and correct and that I have received and understand the HIPAA privacy form.

_____ _____

Signature (Patient/ Parent/ Guardian) Date