ALL FOR KIDS
Anuradha Dubey, MD
4312 Spyres Way
Modesto CA 95356

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

Child's Information:

Last Name:_____First Name:_____Middle Name: _____

Date Of Birth:_____(mm/dd/yyyy) Age:_____ Sex: _____

Race:_____ Ethnicity:_____Language: _____

Mailing Address:_____City_____State_____Zip Code_____

PRIMARY RESPONSIBLE PARENT OR LEGAL GUARDIAN FOR ACCOUNT (GUARANTOR)

Last Name:_____First Name:_____Middle Name: _____

Date Of Birth:_____(mm/dd/yyyy) Relationship To Patient: _____

Mailing Address:_____City_____State_____Zip Code_____

Home Tel:_____Cell Phone:_____Work Tel: _____

Email Address:_____(Please Print Clearly)

Social Security #_____ Driver License # _____

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT)

Last Name:_____First Name: _____

Home Tel #_____Cell # _____

Mailing Address:_____City_____State_____Zip Code_____

Relationship To Patient: _____

By Signing below, I attest that the information provided above is true and accurate. I also acknowledge that by signing, I authorize "All For Kids" to send appointment reminders via TEXT and EMAIL. I may opt out by submitting a written request.

Signature Of Guarantor (Responsible Parent/Guardian)_____Date _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name: _____ ID# _____

Group # _____

Name Of Insured (Policy Holder)

First Name_____Last Name_____

Date Of Birth:_____Social Security Number: _____

Mailing Address:_____City_____State_____Zip Code_____

Telephone #_____ Relationship To Patient: _____

SECONDARY INSURANCE

Insurance Name: _____ ID# _____

Name Of Insured (Policy Holder)

First Name_____Last Name_____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

I authorize the release of information necessary to process claims, and authorize payment of medical benefits directly to the physician for those you bill.

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. If proof of eligibility for my child cannot be verified with the plan provided I understand that I will be entirely responsible for all charges.

I have read all the information contained in this document. I certify that all the information that I have provided is true and correct to the best of my knowledge. I will notify you of any changes to the above information.

Signature Of Guarantor (Responsible Parent/Guardian)_____Date _____

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my child's health information (Protected Health Information or PHI) and medical information by **All For Kids** in order to carry out treatment, payment, or health care operations. You should review the Practice's "Notice of Privacy Practices" for a more complete description of the potential release and use of such information, and you have the right to review such notice prior to signing this Consent Form.

We Reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

By signing, I authorize **All For Kids** to use and/or disclose the following individually identifiable health information about my child, including but not limited to, dates of services, types of services and diagnosis rendered to insurance carriers, other physicians, or agencies to whom a referral for care may be made.

Signature Of Guarantor (Responsible Parent/Guardian)_____Date _____

CONSENT TO TREAT MINOR CHILDREN

I,_____Parent or legal guardian of _____, born_____, do hereby consent to any medical care and the administration of Anesthesia and Vaccines determined by a physician to be necessary for the welfare of my child while said child is under the care of **Anuradha Dubey, MD** and I am available by telephone to give consent, if the above mentioned child is brought to the **All For Kids** clinic by someone other that the legal guardian and is over the age of 18 years.

This Authorization will become effective on the initial visit and will remain effective until I provide written notice of revocation.

Signature Of Guarantor (Responsible Parent/Guardian)_____Date _____

RELEASE OF INFORMATION AUTHORIZATION

Names of individuals, and relationship of persons whom I authorize to release my child's information to and give permission to bring in my child and be responsible for carrying out the directives given to them by **Dr. Anuradha Dubey**. (Please note that the person bringing child is responsible to pay for any copayments due at the time of visit).

Name_____Relationship to Patient _____

Name_____Relationship to Patient _____

Signature Of Guarantor (Responsible Parent/Guardian)_____Date _____