

Pediatric Patient Registration Form

Instructions: Please complete **all applicable fields** below.

Patient Information		
Patient Name (Last, First):		
Date of Birth (DOB):	Sex:	SSN:
(2) Child Name (Last, First):		
DOB:	Sex:	SSN:
(3) Child Name (Last, First):		
DOB:	Sex:	SSN:

Home Address:	
Home Phone #:	Email Address:
What is the family's preferred language?	Would you like an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
How would you like to receive appointment reminders? <input type="checkbox"/> Text Message <input type="checkbox"/> Phone Call <input type="checkbox"/> Do Not Remind	Is the patient employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Employer Name:
Name of Pediatrician:	Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

Patient Contacts	
In case of an emergency , please provide the names of individuals (e.g. parent or grandparent) we should contact below:	
(1) Patient Contact Name:	
Is this emergency contact's address the same as the patient's address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please enter address here:	
Is this person a parent/legal guardian of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home and/or Cell Phone #:	Relationship to Patient: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Neighbor <input type="checkbox"/> Caregiver
(2) Patient Contact Name:	
Is this emergency contact's address the same as the patient's address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please enter address here:	
Is this person a parent/legal guardian of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home and/or Cell Phone #:	Relationship to Patient: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Neighbor <input type="checkbox"/> Caregiver

Guarantor Information

Who is **financially responsible** for the patient's account if there are costs **not covered** by the health insurance plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Someone Else

If **'Someone Else'** please provide their **name and address**:

Guarantor's Sex:

SSN:

DOB:

Relationship to Patient: ☐ Parent/Legal Guardian ☐ Foster Parent ☐ Grandparent ☐ Other Relative

Email Address:

Is this person **currently employed**? ☐ Yes ☐ No

If yes, complete below:

Employer Name:

☐ Full Time ☐ Part Time ☐ Retired

Primary Insurance Information

Name of primary health insurance coverage plan:

Policy ID #:

Group #:

Who is the primary subscriber of the plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

Secondary Insurance Information

Name of secondary health insurance coverage plan:

Policy ID #:

Group #:

Who is the primary subscriber of the secondary plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

How Did You Hear About Us?

☐ Family/Friend ☐ Referring Provider ☐ Internet/TV/Radio ☐ Health Insurance Provider ☐ Not Sure

Name of Referring Provider:

What is the Name and Address of Your Preferred Pharmacy and Lab?

Parent/Legal Guardian Signature:

Today's Date:

Thank you! Please hand this form back to the **registration staff** at the front desk.

Detailed Messages Regarding Healthcare Information Form for Minors

You have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to leave detailed voice messages regarding your child's health information on an answering machine or other voice recording system. If you authorize UBCP providers and staff to leave detailed voice messages this authorization entitles; hospitals, provider offices, home health, etc. to leave detailed information, which may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. Detailed message authorization is optional and not a requirement. UBCP will only leave detailed messages regarding health information for the phone number authorized below and will not leave detailed messages at any other numbers in the record. The authorization to leave detailed voice messages will remain valid until withdrawn in writing, unless specified by a calendar date. **There are risks associated with leaving detailed voice messages regarding your child's health information, including, but not limited to, potential disclosure to a third-party. By signing this authorization form you acknowledge and accept the risks associated with this type of release. If your child's health information is disclosed to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.**

Additionally, you have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to discuss your child's detailed medical information with designated individuals. Such detailed information may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. This authorization is optional and not a requirement. The authorization to discuss your child's detailed medical information with designated individuals will remain valid until withdrawn in writing, unless specified by a calendar date. Please complete the UBCP Authorization for Release of Health Information Form to authorize designated individuals.

Patient Information	
(1) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18 th Birthday:	
(2) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18 th Birthday:	
(3) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18 th Birthday:	

Parent/Legal Guardian Information #1	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	Relationship to Patient:
Parent/Legal Guardian Information #2	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	Relationship to Patient:

Today's Date (Date of Authorization):

Phone Number(s) Authorized for Detailed Messages		
Phone Number	Type	Parent/Legal Guardian
	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> #1 <input type="checkbox"/> #2
	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> #1 <input type="checkbox"/> #2
	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> #1 <input type="checkbox"/> #2

NOTE: *Expiration of authorization automatically occurs on the patient's 18th birthday.*

Specific Date(s) (Optional)	
From:	To:

Signature of Parent/Legal Guardian

Today's Date

Signature of Parent/Legal Guardian

Today's Date

Signature of Witness (required if patient/parent/legal guardian unable to sign)

Today's Date

Relationship to Patient



We Ask Because We Care

Please complete this questionnaire. We use this information to review the treatment patients receive and to ensure that everyone gets the highest quality of care. Your individual responses are private and will not be shared outside the health care system.

1. Do you consider yourself Hispanic/Latino? ☐ Yes ☐ No ☐ Decline to answer
2. How would you describe your Race? By race, we mean the major world group or groups from which your ancestors came. *Please check as many categories as you need to describe yourself.*

- | | | |
|---|--------------------------------|--|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Decline to Answer |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> White | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | | |

3. How would you describe your Ethnicity? By ethnicity, we mean the group or groups with whom you share your cultural identity or customs. *Please check as many categories as you need to describe yourself.*

- | | |
|---|---|
| <input type="checkbox"/> African | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Mexican |
| <input type="checkbox"/> Arab/North African | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Mongolian |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> First Nation (Canada) | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Caribbean/West Indian | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Central American | <input type="checkbox"/> Samoan/American Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> South American |
| <input type="checkbox"/> European/European Descent | <input type="checkbox"/> Thai |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Tibetan |
| <input type="checkbox"/> Guamanian | <input type="checkbox"/> Tongan |
| <input type="checkbox"/> Hmong | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Indigena - Maya | |
| <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other _____ | |

4. In which state and/or country were you born? _____

Please hand this form back to the front desk staff when completed. Thank you.

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given access to a copy of the UCSF Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative. Also, a copy is posted on our website at www.UBCP.org.

Printed Patient Name

Date of Birth (DOB)

If Patient is a Minor, Printed Parent/Legal Guardian or Financial Guarantor Name

Relationship to Patient

Signature of Patient or Parent/Legal Guardian

Today's Date (Date Noticed Received)

Terms and Conditions of Registration, Medical Services and Financial Agreement

1. UCSF Benioff Children's Physicians (UCBP) is part of the University and is comprised of its hospital(s), medical center(s), its hospital-based clinics, and the UCSF School of Medicine.
2. **MEDICAL CONSENT:** I consent to medical treatments or procedures x-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping and laboratory procedures.
3. **RELEASE OF MEDICAL INFORMATION:** The State of California information Practices Act requires UBCP to provide the following information to individuals who supply information about themselves. As a patient of UBCP, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UBCP is authorized to maintain this information. As required by UBCP, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. UBCP will obtain my written authorization to release information about my medical treatment, except in those circumstances when UBCP is permitted or required by law to release information (see UBCP's Notice of Privacy Practices for a description of the specific circumstances under which UBCP may release this information). For example, UBCP may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, UBCP is required by law to report my diagnosis to the State Department of Health Services.
4. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay, co-insurance or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay UBCP for professional and clinic services. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
5. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UBCP of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UBCP, including emergency services, at a rate not to exceed UBCP actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UBCP by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service:

Printed Patient Name	Today's Date
Signature of Parent/Legal Guardian or Financial Guarantor	Today's Date
Signature of Witness (required if patient/parent/legal guardian/financial guarantor unable to sign)	Today's Date
Relationship to Patient	
Signature of Interpreter (if applicable)	Today's Date
Language Used	

Consent to Treatment of a Minor

I, _____, parent or legal guardian of

(Printed Name of Parent/Legal Guardian)

_____, born on _____

(Printed Name of Patient)

(Patient's Date of Birth)

do hereby consent to any medical care and administration of anesthesia, lifesaving procedures and/or

medications determined by a physician to be necessary for the welfare of my child while my child is under the

care of an UBCP clinical facility. This authorization is effective from _____ until

(Today's Date)

consent is withdrawn.

Signature of Parent/Legal Guardian

Today's Date

Other Adult Consent to Treatment (Optional)

I, _____, parent or legal guardian of

(Printed Name of Parent/Legal Guardian)

_____, born on _____

(Printed Name of Patient)

(Patient's Date of Birth)

do hereby authorize _____ to act as my agent to consent to any

(Printed Name Agent/Other Adult)

x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is

deemed advisable by, and is to be rendered under the general or special supervision of, a licensed physician

and/or surgeon regardless of where treatment is provided. This authorization is given pursuant to the

provisions of Family Code section 6910 and is effective from _____ until consent is

(Today's Date)

withdrawn.

Signature of Parent/Legal Guardian

Today's Date

UBCP MyChart Proxy Authorization Form
Granting Proxy Access to Parent/Guardian on behalf of
an ADOLESCENT (Age 12 - 17 years)

PATIENT'S NAME: _____ PATIENT'S DATE OF BIRTH: _____

PATIENT'S MEDICAL RECORD #: _____ Last 4 of Patient Social Security #: _ _ _ _

Important Reminder: UBCP MyChart displays certain information from medical records, but **it does not display all health information** in medical records.

Parent/Legal Guardian of Adolescent: This authorization form is used to establish UBCP MyChart accounts for both the Parent/Legal Guardian and the adolescent patient. This authorization form serves as acknowledgement and permission for my adolescent to have a UBCP MyChart account. Legal papers establishing parental or guardian relationship may be requested. A renewal of this authorization may be requested as well. Expiration of proxy access automatically occurs on the patient's 18th birthday.

I would like to (please circle one) grant / decline my child access to their own individual MyChart account.

AGREEMENT

The UCSF Benioff Children's Physicians (UBCP) Terms and Conditions for UBCP MyChart, and the UBCP MyChart Proxy/Disclaimer for access to My Family's Record in the UBCP MyChart section control this agreement between the patient's Parent/Legal Guardian and UBCP. Please refer to these documents when you signup online.

YOUR RIGHTS

This Authorization to release health information is voluntary. You may revoke proxy access at any time. For revocation, please contact the patient's practice. The Revocation will take effect within 2 business days upon notification of your request except to the extent UBCP or others have already relied on it.

REVOCATION/EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, or ended by revocation, authorization for UBCP MyChart proxy access will not expire unless the relationship between the legal guardian and the patient changes.

Print Name of Parent/Legal Guardian: _____

If the Parent/Legal Guardian is an UBCP patient:

MRN: _ _ _ _ _

Last 4 of Social Security #: _ _ _ _

If the Parent/Legal Guardian is NOT an UBCP patient:

Full Social Security # : _ _ _ - _ _ - _ _ _ (optional)

Sex: Male ___ Female ___

Date of Birth: ___/___/___ (Parent's date of birth)

Patient's Cell Phone # (Age 12-17) for MyChart Sign-up: ___ - ___ - ___

Address: _____

Preferred Language: _____

I attest that the above information is true and correct.

Signature of Child's Parent/Legal Guardian: _____ **Date:** ___/___/___

Practice representative who witnessed this proxy:

_____ (Print Name)

_____ (Signature)

Date: ___/___/___

A copy is as valid as the original.

UBCP MyChart

Parent/Legal Guardian Proxy – ADOLESCENT (Age 12-17 years)

Dear Parent/Legal Guardian,

Thank you for signing the *UBCP MyChart Proxy Authorization* form. This is the first step in allowing you to view some of your adolescent's health information online through UBCP *MyChart* patient portal.

UBCP *MyChart* patient portal is offered to you free of charge as an online resource for routine health care needs. For patients age 12-17, UBCP requires signed approval from the parent or guardian in order for the parent/guardian to view some of the child's health information on MyChart. Proxies would have access to adolescent test results, allergies, and immunizations; they can message their adolescent's providers and request appointments on their adolescent's behalf. **Parents/guardians will not have access to information related to sensitive services**, such as reproductive health (i.e. pregnancy testing, contraception, testing and treatment for sexually transmitted diseases), and certain mental health and substance use screening and treatments. Because certain sections may contain sensitive information, parent proxy access will be limited as follows:

Content	Adolescent (12-17 yrs)	Parent Proxy (≥ 12 yrs)	Parent Proxy (0-11 yrs)
Labs	YES	YES	YES
Immunizations	YES	YES	YES
Allergies	YES	YES	YES
Growth Chart	YES	YES	YES
Messaging to and from Provider*	YES	YES	YES
Appointment Request	YES	YES	YES
Appointment View	YES	NO	YES
Problem List/Summary	YES	NO	YES
Medications/Refill Request	YES	NO	YES

* Parent and teen can send private messages to the provider.

Once your child turns 18, you will be removed from their account and will not see any of their health care information. If you have any questions, please call the patient's practice or UCSF MyChart Customer Service at 415-514-6000 (M-F 8 am -5 pm) or email us at UCSFMyChart@ucsfmedctr.org.