WILSON MEMORIAL HOSPITAL
WILSON CARE, LLC

CHILD REGISTRATION FORM
PATIENT INFORMATION – Child

Name _____ Nickname:_____
Last First MI

Date of Birth: _____-_____-_____ Sex: ____M _____F SSN #:_____

Child's Home Address:_____
Street and PO Box City State Zip

Child's Home #_____ Mother's Name:_____ Father's Name: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other:_____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander
☐ American Indian/Alaska Native ☐ More than 1 race ☐ Undefined

Language:_____ (See Master List of Language Options)

Siblings: _____

Emergency Contact:_____ _____
Name Relationship to patient Phone #

Who is accompanying the child today?

Name: _____Relation:_____

Who does the child reside with primarily: (check all that apply)

☐ Mother ☐ Father ☐ Step Mother ☐Step Father ☐ Guardian (☐ M ☐ F) Name _____

Do you have legal custody of this child? ☐ YES ❒ NO

If no, who has legal custody of the child? _____

AUTHORIZATION FOR TREATMENT &
DISCLOSURES OF PROTECTED HEALTH INFORMATION

The undersigned has been informed of medical treatment considered necessary for the patient whose name appears below and that the treatment and procedures will be performed by Practitioner and/or employees of Wilson Care, LLC Authorization is hereby granted for such treatment and procedures. By signing below you are granting consent to Wilson Care, LLC, operating as a clinically integrated healthcare arrangement composed of Wilson Memorial Hospital, Wilson Care, LLC, Physical Therapy, Home Health Care/Hospice and Wilson Memorial Hospital Medical Staff to use and disclose your protected health information for the purpose of treatment, payment and health care operations.
Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice at all main door entries.
You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

☐ Notice of Privacy Practices ☐ Patient Rights Received ☐ Cancellation and Financial Policies Received

_____ _____
Patient and/or Responsible Party Signature Date

_____ _____
Witness Date

PREFERRED METHOD OF CONTACT

We will contact you by phone and/or email with appointment reminders and lab/procedure results. Please note that we will never leave a message with abnormal lab results. In this case, if we reach your voicemail, we will leave limited information and request a call back. Please list all methods of contact that are acceptable to you.

Phone Numbers: If the numbers are not for you please list first and last name along with the relationship of the person you wish for us to contact. Please place an "X" in the box next to your preferred method of contact.

☐ Home # ☐ Cell # ☐ Work # ☐ Email ☐ Other: _____

AUTHORIZATION FOR PERSONAL DISCLOSURES

Our policy here at Wilson Care LLC is not to disclose any private protected healthcare information regarding your child to family members, friends, or other relatives. We will be unable to release any information about your child's healthcare without your written consent. Your signature below indicates that you give permission for the person(s) listed to receive information related to your child's health. If you wish to have your child's private healthcare or treatment information released to another individual you must read and complete the following:

Authorized Person(s):

Name: _____ **DOB:** _____
Last First MI
Relationship to patient:_____ **Phone #:**_____

Name: _____ **DOB:** _____
Last First MI
Relationship to patient:_____ **Phone #:**_____

Name: _____ **DOB:** _____
Last First MI
Relationship to patient:_____ **Phone #:**_____

Name: _____ **DOB:** _____
Last First MI
Relationship to patient:_____ **Phone #:**_____

I authorize Wilson Care, LLC to release information specified below to the individual(s) named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication to appropriate individuals. I understand that with this authorization, all information contained in my chart/file may be released unless otherwise indicated.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by privacy regulations, the information described above my be disclosed and is no longer protected by those regulations.

I understand that this authorization will remain valid indefinitely unless otherwise revoked by me in writing. I also understand that I may revoke this authorization in writing at any time by notifying staff, except to the extent that action has already been taken in reliance on this authorization.

_____ _____
Signature of patient or parent/legal guardian **Date**