# Registration

**Date: _____**

**Child's Name: _____ Date of Birth: ___/___/_____ M/F**

**Child's Name: _____ Date of Birth: ___/___/_____ M/F**

**Child's Name: _____ Date of Birth: ___/___/_____ M/F**

**Child's Name: _____ Date of Birth: ___/___/_____ M/F**

**Child's Name: _____ Date of Birth: ___/___/_____ M/F**

## Parent/Legal Guardian

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

**Address: _____City: _____ State/Zip _____**

**Home Phone: (____) _____ Cell: (_____) _____ Email: _____**

**Employer: _____ Work Phone: (_____) _____**

## Other Parent/Legal Guardian

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

**(If different from above)**

**Address: _____City: _____ State/Zip _____**

**Home Phone: (____) _____ Cell: (_____) _____ Email: _____**

**Employer: _____ Work Phone: (_____) _____**

**Preferred Contact Number: ( _____ ) _____**

**Primary Insurance Holder:**

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

**Emergency Contact:**

**Name: _____ Phone Number: ( _____ ) _____**

**Relationship to Parent/Guardian: _____**

**Race:** ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American**

☐ **Hispanic** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **White** ☐ **Other Race**

**Ethnicity**: ☐ **Hispanic** ☐ **Non-Hispanic** **Language Spoken at Home: _____**

**How did you find our practice?**

**Internet Search:** ☐ **Google** ☐ **Facebook** ☐ **Yelp** ☐ **Insurance Website**

**Print Media**: ☐ **Newspaper** ☐ **Business Directory** ☐ **Phone Book**

**Friend Referral**: ☐ **OB-GYN Referral**: ☐ **Other:** ☐_____

## Vaccine Policy

**We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics. If you have doubts or concerns about any vaccines, we will do our best to address your concerns. If you refuse to vaccinate your child despite our recommendations, we will kindly ask you to find another health care provider who would share your views.**

## Children's IQ Network

**Our practice participates with Children's National Health System's IQ Network (CIQN) to share electronic medical records with specialists and hospitals and ER's in the network to provide quality and coordinated care. CIQN is HIPAA compliant, and the record is encrypted (encoded) and can be accessed only by the health care providers who are caring for your child and have need to know. I understand that I do have the right to opt out to participate in the Children's National IQ Network by signing a consent form. You can ask the receptionist for more information and also about the consent form if you decide to opt out.**

# Consent for Treatment

**I give consent to treatment and medical care of my children as listed above by Dr. Kenneth J. Kim, who will perform treatments that in his judgment is deeded medically necessary. I will be financially responsible for services rendered including office visit, labs, tests, forms, and other incurring charges. I also have read and understood the vaccine policy of the office.**

_____ _____

Signature of Parent or Legal Guardian Relationship to Patient

_____ _____

Print Name of Person Signing Date