New Patient Registration

Drs. Chhabra & Sait, MD PA

1. Patient Demographics

Child's Full Name

Date of Birth:

Preferred Name:

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Decline to Specify

Home Address:

Primary Phone:

2. Ethnicity & Race

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ American Indian/Alaskan ☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Unknown

3. Family & Custody Information (Check all that apply)

	Mother	Father	Guardian	Other
Person Financially Responsible	☐	☐	☐	☐
Who Has Custody	☐	☐	☐	☐
Who Does the Child Live With	☐	☐	☐	☐

4. Parent / Guardian Contact Information

Biological Mother: Full Name: DOB:

Cell: → Use for portal registration:

Email: → ☐ Yes ☐ No

Employer:

Biological father: Full Name: DOB:

Cell: → Use for portal registration:

Email: → ☐ Yes ☐ No

Employer:

Legal Guardian (if different): DOB:

Cell: → Use for portal registration:

Email: → ☐ Yes ☐ No

Employer:

Divorced Parents: Are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or obtaining information about the child's medical treatment? ☐ Yes ☐ No

If yes, please provide supporting legal paperwork.

Stepparent:

DOB: Cell: Email:

Employer:

Please do not forget to complete the reverse side of the form

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Drs. Chhabra & Sait, MD PA

5. Sibling Information

Full Siblings Seen in Office: ☐ Yes ☐ No ☐ No full siblings

Name	Date of Birth	Sex
		☐ M ☐ F ☐ Other
		☐ M ☐ F ☐ Other
		☐ M ☐ F ☐ Other
		☐ M ☐ F ☐ Other

Half Siblings Seen in Office: ☐ Yes ☐ No ☐ No half siblings

Name	Date of Birth	Sibling by Mother Father	Sex
			☐ M ☐ F ☐ Other
			☐ M ☐ F ☐ Other
			☐ M ☐ F ☐ Other

Preferred Pharmacy:

Address:

Emergency Contact: Name:

Relationship: Phone:

8. Insurance information

Primary Insurance: Policy #

Policy Holder Name: Date of birth:

Secondary Insurance: Policy #

Policy Holder Name: Date of birth:

9. Authorization & Acknowledgment

Patient Authorization & Assignment: I authorize Drs. Chhabra & Sait, MD, PA, to apply for benefits on behalf of patients listed, for services they render, and receive payment directly from my insurance company. I certify that the information provided about my insurance coverage is accurate and authorize the release of any necessary information, including medical information, for claim processing. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for services not covered by insurance.

Name of Insured/Beneficiary: Sign/Date:

Please do not forget to complete the reverse side of the form

10. Additional Consents & Acknowledgments

I consent to the use of **secure telemedicine** for my/my child's medical care, understanding its benefits, risks, and limitations.

I consent to the use of an **AI-assisted documentation** system under clinician supervision for accurate and secure medical record-keeping

Detailed Telemedicine and AI Scribe Consent statements are included in the New Patient Information Packet, which I have reviewed and understood.

Signature of Parent/Guardian: Date:

Authorization for Accompaniment and Limited Medical Discussion

Purpose: This form lets parents permit someone else to bring their child to visits and talk with the doctor about the child's care.

Note: Parents or legal guardians must be present for any vaccines or procedures that need consent.

1. Type of Visit (check all that apply)

- ☐ Sick Visit
- ☐ Follow-Up or Recheck
- ☐ Medication Check
- ☐ Physical Exam
- ☐ Behavior / Mental Health Visit

2. Information That May Be Discussed (check all that apply)

- ☐ Current Symptoms
- ☐ Medications / Prescriptions
- ☐ Test or Lab Results
- ☐ Treatment Plan / Next Steps
- ☐ Medical History

3. Patient Information

Child's Name Date of Birth:

4. **Authorized Person(s)** Allowed to Bring Child and Talk with Doctor

Full Name Relation to the patient Phone:

5. **Parent/Guardian Authorization**

By signing below, I authorize the above-listed individuals to accompany my child(ren) for the selected visit types and participate in the medical discussions checked above. I understand that this authorization **does not permit consent for vaccinations or invasive procedures** unless I am present or provide **separate written consent**.

Parent/Guardian Name: Sign/date

Please do not forget to complete the reverse side of the form

Patient Plate – Office Use Only

Medical Record Number:
_____

Drs. Chhabra & Sait, MD, PA

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical practice listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, sexually transmitted disease information, alcohol and substance use disorder treatment information, mental health treatment information, family planning and genetic testing information from my health care provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of [Company], its staff, and its business associates.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

Description of Delagation of Authority: