Beacon Pediatrics

18947 John J Williams Hwy. Suite 212
Rehoboth Beach, DE 19971
P: (302) 645-8212 F: (302) 645-2199

32566 Docs Place, Suite 1
Millville, DE 19967
P: (302) 537-0793 F: (302) 537-0795

18 AND OLDER UPDATED REGISTRATION

Patient Name: _____**DOB:** _____

PHONE: (_____) _____ - _____ **Email Address:** _____@_____

ADDRESS: _____
STREET CITY STATE ZIP

IS GUARANTOR (FINANCIALLY RESPONSIBLE PARTY) ADDRESS THE SAME AS PATIENT'S ADDRESS?
IF NO PLEASE PROVIDE GUARANTOR'S ADDRESS:

ADDRESS: _____
STREET CITY STATE ZIP

Parent/Guardian Name:_____ **Phone:** (_____) _____ - _____

Parent/Guardian Name:_____ **Phone:** (_____) _____ - _____

Emergency Contact #1:

Name:_____ Relation to patient: _____ Phone: (_____) _____ - _____

Emergency Contact #2:

Name:_____ Relation to patient: _____ Phone: (_____) _____ - _____

Please check the following if you **ALLOW** our office to speak with your parent/guardian in regards to you and your chart:

❑ Reminder calls and scheduling (after/or if we cannot reach you) ❑ Patient Portal ❑ Office visits

❑ Immunizations ❑ Lab/Imaging Results ❑ (FOR FEMALES) - birth control/pregnancy ❑ Hospital/Walk-in

❑ Therapy Reports ❑ Drug/Alcohol Reports ❑ HIV/AIDS Reports ❑ Psychiatric/Psychology Notes

This consent serves as permission for treatment by **Beacon Pediatrics, LLC** and its providers/staff. Consents are not required in emergency situations. I agree to pay for all services provided. This authorization shall remain effective unless requested by me in writing **OR** until the following date listed: _____ **(VALID UNTIL A CERTAIN DATE)**

_____ _____
SIGNATURE **DATE**