PEDIATRIC - PATIENT REGISTRATION

DATE

Formedic

NAME		M F DATE OF BIRTH		AGE
STREET ADDRESS		CITY STATE, ZIP		PHONE ( )
SCHOOL		REFERRED BY		
FATHER'S NAME	OCCUPATION / EMPLOYER	DATE OF BIRTH	WORK PHONE ( )	S.S. #
MOTHER'S NAME	OCCUPATION / EMPLOYER	DATE OF BIRTH	WORK PHONE ( )	S.S. #
GUARDIAN (OTHER, SELF)	OCCUPATION / EMPLOYER	DATE OF BIRTH	WORK PHONE ( )	S.S. #
EMERGENCY CONTACT (OTHER THAN PARENTS)		ADDRESS		PHONE ( )
CLOSEST RELATIVES (NOT AT YOUR ADDRESS)		ADDRESS		PHONE ( )

INSURANCE & BILLING INFORMATION

PERSON RESPONSIBLE -	☐ FATHER ☐ MOTHER	☐	RELATIONSHIP	
BILLING ADDRESS				PHONE #

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY		ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME		I.D. #	GROUP #	BENEFIT CODE
2) INSURANCE COMPANY		ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME		I.D. #	GROUP #	BENEFIT CODE
OTHER COVERAGE				

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. _____ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE — MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT NAME *(please print)* ..... DATE .....

PARENT / GUARDIAN *(please print)* ..... SIGNATURE .....

HIPAA COMPLIANT