Primary Pediatric Medical Group

PATIENT REGISTRATION

Primary Language_____ Primary Physician_____ Referred by_____

Home Address_____Phone _____
Street Apt. # City State Zip

Please list all children in family and PRINT CLEARLY. Use a 2nd form for more than 3 children. (Copies will be made for each child's medical record with that child's name highlighted.)

Child _____ Birth date_____ Boy___ Girl___
Last First Middle

Child_____ Birth date_____ Boy___ Girl___
Last First Middle

Child _____ Birth date_____ Boy___ Girl___
Last First Middle

Emergency Contact (Friend or Relative **other than parent**)

Name _____ Phone #_____ Relation to patient_____

MOTHER/PARENT	*FATHER/PARENT*
Financially responsible? ☐ Yes ☐ No	Financially responsible? ☐ Yes ☐ No
Name _____	Name_____
Birth date _____ SS#_____	Birth date _____SS#_____
Billing address if different from child's:	Billing address if different from child's:
Street City State Zip	Street City State Zip
Mobile phone Email	Mobile phone Email
Employer	Employer
Occupation	Occupation
Employer Address	Employer Address
Employer phone #	Employer phone #

INSURANCE INFORMATION: (PRIMARY: This is the parent whose birthday occurs first in the calendar year)

Primary Carrier: _____Birthdate: _____
Subscriber Name

PLEASE PRESENT INSURANCE CARD FOR COPYING

Please remember that some insurance companies pay fixed allowances for certain procedures, while others pay a percentage of the charges. It is your responsibility to pay any deductible amount, any co-insurance, or any other balances not paid for by your insurance. If your insurance company delays the processing of the claim, you must make payment starting 30 days after the billing date.

With my signature below, I give my consent for diagnostic and treatment services and assign all medical benefits to which I am entitled to the physicians. This assignment will remain in effect until revoked by means of a certified letter to this office and the insurance company (ies). A photocopy of this assignment is to be considered as valid an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____ _____
Date Signature Print name here

8/16/2013