Bambini Pediatrics PC

Wholesome Medical Care for Kids

PATIENT REGISTRATION FORM

Patient Information

Patient Last Name:	First Name:	MI:	Today's Date:
Date of Birth:	Patient SSN#:	Home Phone #:	
Race:	Ethnicity:	Language:	
Home Street Address:	City:	State:	Zip Code:
Primary Doctor (PCP):	Preferred Pharmacy:	Preferred Laboratory:	

Responsible Party

Last Name:	First Name:	MI:	Relationship to Patient:
Date of Birth:	SSN#:	Home Phone #:	
Work Phone: Ext:	Cell Phone:	E-Mail:	
Home Street Address:	City:	State:	Zip Code:

Insurance Plan

Primary Insurance Company:	Group #:	Policy #:	:
Copayment:	Effective Date:	Policy Holder Name:	
Insurance Address:			

Authorization

I authorize the release of any medical information necessary to process insurance claims and the release of information back to my physician. I also authorize payment of medical benefits to Bambini Pediatrics for services rendered. *In the event that my medical insurance does not pay for the services rendered, I agree to pay Bambini Pediatrics the usual and customary fees for these services. Also, in the event that my insurance has terminated or that I did not choose Bambini Pediatrics as my child's pediatrician, I agree to be responsible for any balance due.*

Signed: _____ Date: _____

PS -- How Did You Hear About Us?