

PEDIATRIC PROFESSIONAL ASSOCIATES, P.C.

PATIENT REGISTRATION FORM

PATIENT/PARENT INFORMATION

TODAY'S DATE: _____

PATIENT LEGAL LAST NAME: _____ LEGAL FIRST NAME: _____ M.I. _____
OTHER NAME (NICKNAME) _____ BIRTHDATE: ____/____/____ GENDER: M F
OTHER CHILDREN IN FAMILY: _____ D.O.B.: ____/____/____

PATIENT LIVES WITH: MOTHER FATHER BOTH OTHER (relationship) _____
MOTHER OR GUARDIAN NAME: _____ DOB: ____/____/____ SS# _____
STREET ADDRESS: _____ CITY, ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
EMAIL ADDRESS: _____

FATHER OR GUARDIAN NAME: _____ DOB: ____/____/____ SS# _____
STREET ADDRESS: _____ CITY, ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____ PH# _____

INSURANCE INFORMATION (Please complete and provide a copy of your insurance card)

PRIMARY INSURANCE: _____ EMPLOYER: _____
POLICY ID# _____ GROUP# _____
POLICY HOLDER NAME: _____ DOB: ____/____/____ SS# _____
RELATION TO POLICY HOLDER: CHILD SELF OTHER: _____

SECONDARY INSURANCE: _____ EMPLOYER: _____
POLICY ID# _____ GROUP# _____
POLICY HOLDER NAME: _____ DOB: ____/____/____ SS# _____
RELATION TO PLOICY HOLDER: CHILD SELF OTHER: _____

Assignment of Insurance Benefits: I hereby authorize payment of medical benefits directly to Pediatric Professional Associates, P.C. I further authorize the release of any medical information necessary for processing the insurance claim. I permit a copy of this authorization to be as valid as the original. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations.

Permission to Treat a Minor (Under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Pediatric Professional Associates P.C. to treat my child in their office as required by the events of that emergency situation.

PARENT/LEGAL GUARDIAN SIGNATURE

DATE