PEDIATRIC PROFESSIONAL ASSOCIATES, P.C.

REGISTRATION FORM

PATIENT INFORMATION

Lives with: M=Mother, F= Father, B= Both

Patients Name: _____ DOB: ____/____/____ M F B Other:_____

Include All _____ DOB: ____/____/____ M F B Other: _____

Children in _____ DOB: ____/____/____ M F B Other: _____

Family _____ DOB: ____/____/____ M F B Other:_____

_____ DOB: ____/____/____ M F B Other:_____

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: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

(NOT LIVING WITH PATIENT)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

CALL BACK AUTHORIZATION

If you have called our office for any reason we recognize how important it is to receive a call back in a timely manner. In order for us to effectively and efficiently deliver information to you when you are not available, we request your permission to give information to whomever you designate as authorized. Please check below the boxes that apply and list the name of a person we may speak to if necessary.

I authorize Pediatric Professional Associates to leave any message on my:

Please Circle: **Answering Machine at Home** **Cell Phone Voice Mail** **Work Voice Mail** **All**

I authorize Pediatric Professional Associates to leave a message with or speak to: _____
Relationship to patient: _____ regarding any information that needs to be relayed to legal guardian.

Please list any exceptions or instructions: _____

----------**PLEASE COMPLETE BACK SIDE ALSO** ----------

COURTESY AND RESPECT POLICY

Pediatric Professional Associates, PC endorses treatment of our patients and their families with courtesy and respect. To maintain a successful working relationship, Pediatric Professional Associates, PC expects mutual courtesy and respect from their patients and families in return. Failure to maintain a successful working relationship may result in termination of care at Pediatric Professional Associates, PC.

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.

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 POLICY 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.

_____ _____

PARENT/LEGAL GUARDIAN/PATIENT SIGNATURE DATE