PATIENT REGISTRATION

THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVICE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION. PLEASE PRINT. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

FAMILY LAST AME_____

MOTHERS NAME_____ FATHERS NAME_____

CHILD(REN)_____ DATE OF BIRTH_____SEX_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ADDRESS_____

CITY_____STATE_____ZIP CODE_____

PHONE (HOME)_____CELL_____WORK_____

RESPONSIBLE PARTY_____RELATIONSHIP_____

ADDRESS (IF DIFFERENT FROM PATIENT)_____

_____

INSURANCE INFORMATION

NAME OF INSURED_____

RELATIONSHIP TO PATIENT_____BIRTHDATE_____

NAME OF EMPLOYER_____

ADDRESS OF EMPLOYER_____

CITY_____STATE_____ZIP CODE_____

NAME OF INSURANCE CARRIER_____

ADDRESS OF INSURANCE_____

CITY_____STATE_____ZIP CODE_____

INSURANCE ID NUMBER_____GROUP #_____COPAY_____

WHO REFERRED YOU TO OUR PRACTICE_____

I authorize release of any information concerning my child's healthcare advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable directly to the Doctor.

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Signature of Parent/Guardian Date