PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Home Address _____

City _____ State _____ Zip Code _____Home Phone Number _____

Date of Birth _____ Social Security Number _____

PARENT'S INFORMATION

Mother's Name_____Cell Phone Number_____

Occupation _____Employer _____Phone Number_____

Father's Name _____Cell Phone Number_____

Occupation _____Employer _____Phone Number_____

How did you hear about us/referred by?_____

Email Address_____ May we contact you by email?_____

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber _____Date of Birth _____ SS #_____

Policy/Group/ID Number _____Relationship to Child _____

Secondary Insurance_____

Subscriber _____Date of Birth _____ SS #_____

Policy/Group/ID Number _____Relationship to Child _____

BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the parent is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to a collection for non-payment after 90 days, then the parent is responsible for the bill, the interest, and collection and attorney fees.

Authorization to pay benefits to Children's Medical Group/ I hereby authorize payment directly to Children's Medical Group for any charges.

Authorization to release information/I hereby authorize Children's Medical Group to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.

Signature of Parent/Guardian _____ Date _____