

# Primary Care Pediatrics, PC

## Registration Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ **Primary Insurance:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ M / F Policy/Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Policy/Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

School Name: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Siblings: \_\_\_\_\_

Family Email: \_\_\_\_\_

### Father/ Guardian

### Mother/ Guardian

Name: \_\_\_\_\_ Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

SS#: \_\_\_\_\_ SS#: \_\_\_\_\_

DOB: \_\_\_\_\_ Cell #: \_\_\_\_\_ DOB: \_\_\_\_\_ Cell #: \_\_\_\_\_

Home #: \_\_\_\_\_ Home #: \_\_\_\_\_

### PATIENT INFORMATION

Work #: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

#### \*\*\*\*\*PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST\*\*\*\*\*

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by **Primary Care Pediatrics, PC**. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.
- I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of **Primary Care Pediatrics, PC** as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to **Primary Care Pediatrics, PC** for services rendered.

**I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and Insurance authorization.**

\_\_\_\_\_  
Patient/ Parent or Guardian Signature

\_\_\_\_\_  
Please Print Patient/ Parent or Guardian Name

\_\_\_\_\_  
Date

### PARENT / GUARDIAN INFORMATION

### AUTHORIZATIONS