PATIENT REGISTRATION

IMPORTANT INFORMATION – PLEASE COMPLETE

PATIENT NAME: _____ SEX: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE

STREET ADDRESS: _____ APT. NO.: _____

CITY/STATE: _____ ZIP: _____

PRIMARY NUMBER: _____ Permission to leave voice mail at primary number? ☐ YES ☐ NO

MOTHER'S NAME: _____ DOB: _____ S.S.# _____

FATHER'S NAME: _____ DOB: _____ S.S.# _____

OTHER/GUARDIAN: _____ DOB: _____ S.S.# _____

PRIMARY EMAIL ADDRESS: _____

PORTAL REGISTRATION: ☐ YES ☐ NO

EMERGENCY CONTACT _____ PHONE: _____

ADDITIONAL CONTACT _____ PHONE: _____

NEWBORN: HOSPITAL BABY BORN IN: _____ SEEN BY DR.: _____

EMPLOYER INFORMATION

IMPORTANT INFORMATION – PLEASE COMPLETE

FATHER/GUARDIAN: _____

PHONE: _____

EMPLOYER: _____

EMPLOYER STREET ADDRESS: _____

CITY: _____

STATE/ZIP: _____

MOTHER/GUARDIAN: _____

PHONE: _____

EMPLOYER: _____

EMPLOYER STREET ADDRESS: _____

CITY: _____

STATE/ZIP: _____

INSURANCE INFORMATION

IMPORTANT INFORMATION – PLEASE COMPLETE

INSURANCE CO. NAME: _____ TELEPHONE: _____

BILLING ADDRESS: _____ CITY/STATE: _____ ZIP: _____

I.D. or CONTRACT #: _____ GROUP #: _____

CONSENT FOR TREATMENT and INSURANCE AUTHORIZATION and ASSIGNMENT (please read and sign)

IMPORTANT INFORMATION – PLEASE READ AND SIGN BELOW

1. The patient or his representative recognizing the need for care, consents to The Pediatric Center, P.A. services as ordered by the physician, including laboratory procedures, medical treatment, minor or emergency surgical treatment, examination, or other services rendered under the general and specific instructions of the physician.
2. I hereby authorize The Pediatric Center, P.A. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

PRIMARY LANGUAGE SPOKEN IN HOUSEHOLD: _____

_____ Date

_____ Signature of Legal Guardian

PC-F207