PRIMARY PEDIATRICS PATIENT REGISTRATION FORM

Today's Date_____

PATIENT INFORMATION (PLEASE PRINT) ☐ **New** ☐ **Update**

Full Name _____
Last First MI

Date of Birth _____ Sex ☐ Male ☐ Female Social Security #_____

Home Address _____

City, State, Zip _____

Home Phone _____ **Account #**_____

PATIENT INFORMATION -- SIBLING **Account #**_____

Full Name _____
Last First MI

Date of Birth _____ Sex ☐ Male ☐ Female Social Security #_____

PATIENT INFORMATION -- SIBLING **Account #**_____

Full Name _____
Last First MI

Date of Birth _____ Sex ☐ Male ☐ Female Social Security #_____

PATIENT INFORMATION -- SIBLING **Account #**_____

Full Name _____
Last First MI

Date of Birth _____ Sex ☐ Male ☐ Female Social Security #_____

PARENT OR GUARDIAN INFORMATION **Account #**_____

Full Name _____
Last First MI

Date of Birth _____ Sex ☐ Male ☐ Female Social Security #_____

Home Address _____

City, State, Zip _____

Home Phone _____Cell Phone_____Work Phone _____Ext_____

Employer_____

Relationship to Patient ☐ Parent ☐ Guardian ☐ Other (explain)

PARENT OR GUARDIAN INFORMATION

Full Name _____
Last First MI

Date of Birth _____ Sex ☐ Male ☐ Female Social Security #_____

Home Address _____

City, State, Zip _____

Home Phone _____Cell Phone_ _____Work Phone _____Ext_____

Employer_____

Relationship to Patient ☐ Parent ☐ Guardian ☐ Other (explain)

INSURANCE INFORMATION (Please provide the receptionist with your card to photocopy)

Insurance Company Name: _____ Copay Amount $ _____

Policy # / ID _____Group # _____

Policy Holder's Full Name _____ DOB_____ Sex ☐ Male ☐ Female

Social Security # _____Relationship to Patient ☐ Parent ☐ Other (explain) Effective Date _____

Secondary Insurance Name _____ Copay Amount $ _____

Policy # / ID _____ Group # _____

Policy Holder's Full Name _____ DOB_____ Sex □ Male □ Female

Social Security # _____ Relationship to Patient ☐ Parent ☐ Other (explain) Effective Date _____

EMERGENCY CONTACT Nearest Friend or Relative not living in your household

Name_____ Home phone_____

Relationship to Patient _____ Work phone_____

As a patient you have certain responsibilities for your care. Those responsibilities include:

- Providing current, accurate billing information at all visits including a copy of insurance card
- Providing physician with complete medical history
- Being aware of your insurance coverage, including which benefits are and which are not covered

Co-pays must be paid at the time of the visit. Failure to do so will result in an additional fee.

Failure to cancel appointment at least 24 hours in advance will result in a fee.

There will be a $35.00 fee for returned checks.

I hereby authorize treatment by Primary Pediatrics and agree to pay all fees and charges for such treatment. I authorize the release of any pertinent information to my insurance company and any other doctors involved in my care.

I hereby authorize my insurance benefits to be paid directly to Primary Pediatrics. I agree to be financially responsible for any balance due. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 90 days will be assessed a late fee on the unpaid balances.

My signature acknowledges understanding and consent to all of the above information.

Signature _____ Date _____

Patient or Parent/Guardian if signing for minor