PATIENT REGISTRATION FORM

Date: ______/______/_______

PATIENT INFO

PATIENT Full Legal Name ____________________________________ **SS #** _________________

Date of birth______________Home Address ____

_______________________________ **City:** _______________________ **State** ______ **Zip** __________

Ethnicity: □ Non-Hispanic □ Hispanic □ Not specified. **Preferred language:**

Race: □ African or African American. □ Asian or Asian American. □ Caucasian or European American.
□ Native American or Native Alaskan. □ Native Hawaiian or other Pacific Islander. □ Other race

PARENT/ GUARDIAN INFO

Parent/Guardian Name______________________________________Relationship to Child___________

Birth Date_________________SS # ____

Home Address ____

Phone numbers (H)___________________(Cell)__________________(W) _____________________

INSURANCE INFO/ RESPONSIBLE PARTY

Insurance company____Group #___________________

Child's ID #____________Insurance policy holder's name ____________________________________

SS #________________________Relationship to child ____

EMERGENCY CONTACT INFO (not living with patient)

Name________________________________**Relationship**________________Ph # _________________

I hereby assign the benefits from any insurance or third party to PEDIATRIC POD for medical services provided to my child. I understand that PEDIATRIC POD has the right to decline or accept assignment of such benefits. If these benefits are not assigned to PEDIATRIC POD, I agree to forward to the practice, upon receipt, any insurance or third-party payments I receive for services rendered to me. I authorize the release of any medical information needed to determine the benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Parent/Guardian Signature_____________________________________Date ______________________