PATIENT REGISTRATION

THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVICE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION. PLEASE PRINT. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

FAMILY LAST AME____

MOTHERS NAME_______________________ FATHERS NAME_______________________

CHILD(REN)_______________________ DATE OF BIRTH_______________ SEX__________

_______________________ _______________ __________

_______________________ _______________ __________

_______________________ _______________ __________

ADDRESS____

CITY_______________________STATE_______ZIP CODE_______________________

PHONE (HOME)_______________________CELL_______________WORK_______________

RESPONSIBLE PARTY_______________________________RELATIONSHIP__________

ADDRESS (IF DIFFERENT FROM PATIENT)_______________________________________

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INSURANCE INFORMATION

NAME OF INSURED____

RELATIONSHIP TO PATIENT_______________________BIRTHDATE_______________________

NAME OF EMPLOYER____

ADDRESS OF EMPLOYER____

CITY_______________________STATE_______________ZIP CODE_______________

NAME OF INSURANCE CARRIER____

ADDRESS OF INSURANCE____

CITY_______________________STATE_______________ZIP CODE_______________

INSURANCE ID NUMBER_______________________GROUP #__________COPAY__________

WHO REFERRED YOU TO OUR PRACTICE_______________________________________

I authorize release of any information concerning my child's healthcare advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable directly to the Doctor.

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Signature of Parent/Guardian Date