

# PATIENT REGISTRATION FORM

**PLEASE PRINT. THIS INFORMATION IS PART OF YOUR CHILD'S PERMANENT RECORD**  
**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M I \_\_\_\_\_  
Address \_\_\_\_\_ Apt/Unit# \_\_\_\_\_  
Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex  Male  Female SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**PARENT/GUARDIAN WHOM SHOULD WE SEND BILLS TO? \_\_\_\_\_**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M I \_\_\_\_\_  
Address \_\_\_\_\_ Apt/Unit# \_\_\_\_\_ Sex  Male  Female  
Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DL Number \_\_\_\_\_ Issuing State \_\_\_\_\_  
Employer \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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**OTHER PARENT/GUARDIAN**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M I \_\_\_\_\_  
Address \_\_\_\_\_ Apt/Unit# \_\_\_\_\_ Sex  Male  Female  
Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DL Number \_\_\_\_\_ Issuing State \_\_\_\_\_  
Employer \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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**PRIMARY INSURANCE CARRIER**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M I \_\_\_\_\_  
Address \_\_\_\_\_ Apt/Unit# \_\_\_\_\_ Sex  Male  Female  
Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DL Number \_\_\_\_\_ Issuing State \_\_\_\_\_  
Employer \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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**OTHER CHILDREN**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_

**PRIMARY INSURANCE COMPANY**

Insurance Company Name \_\_\_\_\_

We will need a copy of current insurance identification card. If you do not have a current insurance identification card, please complete the section below (must be complete to file the visit with your insurance company. If unable to complete, the visit will be on a cash payment basis.)

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Group #: \_\_\_\_\_

(Must have) \_\_\_\_\_ Employer: \_\_\_\_\_

\_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

CoPay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION / FINANCIAL RESPONSIBILITY**

I hereby authorize payment directly to physicians providing services for which benefits are payable.

I hereby authorize the release of pertinent medical information to insurance carriers. I understand this includes information regarding HIV, mental illness, and drug abuse.

I understand that regardless of what insurance plan I may have, if my insurance carrier does not remit payment as agreed, I will be ultimately responsible for those charges that are not paid by a third party. I further understand that an 18% service charge will be added to accounts 30 days in arrears. I take full responsibility for the charges incurred under any circumstances.

Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Referred By \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact Name & Phone Number \_\_\_\_\_