

Patient:

DOB:

Date:

CHILD REGISTRATION FORM

Gender: ___male ___female

Street _____ Apt.No. _____ City _____ State _____ Zip _____

() _____
Home phone

() _____
Cell or alternate phone

Father's name _____ Father's Social Security# _____

Mother's name _____ Mother's Social Security# _____

_____/_____/_____ (Required for insurance billing)
Father's birth date

_____/_____/_____ (Required for insurance billing)
Mother's birth date

Address (If different from patient)

Address (if different from patient)

Employer (work phone)

Employer (work phone)

For billing purpose: Does child live with; ___ mother and father, ___ mother, ___ father, ___ other _____

PRIMARY Insurance company: _____ Subscriber name: _____ Grp# _____

Address _____ SS#/ID# _____

Subscriber's birthdate ____/____/_____ (required for insurance billing)

SECONDARY Insurance company: _____ Subscriber name: _____ Grp# _____

Address _____ SS# / ID# _____

Subscriber's birthdate ____/____/_____ (required for insurance billing)

Emergency Contact: _____ phone number _____

Referring Doctor () phone

Primary Care Doctor () phone

address

address

Other family members seen in office

I hereby authorize the release of any medical or other information necessary to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any non-covered charges and charges incurred by a collection agency in collecting any unpaid balances. **There is a \$25.00 fee for appointments not cancelled within 24 hours prior to the appointment.**

_____/_____/_____
Signature of responsible party Date

CO-PAYMENT IS DUE AT THE TIME OF SERVICE.

A billing fee will be added to any copay not received in full at your appointment.