Primary Pediatric Medical Group, Inc

PATIENT REGISTRATION

Primary Language_____________ Primary Physician________________ Referred by__________________

Address ____Phone _______________

Street Apt. # City State Zip

Please list all children in family and PRINT CLEARLY. Use a 2nd form for more than 3 children. (Copies will be made for each child's medical record with that child's name highlighted.)

Child ____ Birth date_____________ Boy___ Girl___

Last First Middle

Child____ Birth date_____________ Boy___ Girl___

Last First Middle

Child ____ Birth date_____________ Boy___ Girl___

Last First Middle

Emergency Contact (Friend or Relative **other than parent**)

Name ______________________ Phone #_________________ Relation to patient____________________

Name of financially responsible person____(and relationship)

Billing address____

If different from mother/father/home address – do not list insurance company here

Parent Information:

MOTHER/PARENT	*FATHER/PARENT*
Name ____	Name____
Birth date ________________ SS#__________________	Birth date ________________SS#__________________
Home address if different from child's:	Home address if different from child's
Street City State Zip	Street City State Zip
Mobile phone Email	Mobile phone Email
Employer	Employer
Occupation	Occupation
Employer Address	Employer Address
Employer phone #	Employer phone #

INSURANCE INFORMATION: (PRIMARY: This is the parent whose birthday occurs first in the calendar year)

Primary Carrier: ____Birthdate: __________________________________

Subscriber Name

PLEASE PRESENT INSURANCE CARD FOR COPYING

Please remember that some insurance companies pay fixed allowances for certain procedures, while others pay a percentage of the charges. It is your responsibility to pay any deductible amount, any co-insurance, or any other balances not paid for by your insurance. If your insurance company delays the processing of the claim, you must make payment starting 30 days after the billing date.

With my signature below, I give my consent for diagnostic and treatment services and assign all medical benefits to which I am entitled to the physicians. This assignment will remain in effect until revoked by means of a certified letter to this office and the insurance company (ies). A photocopy of this assignment is to be considered as valid an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

__________ ____ ____

Date Signature Print name here