

Patient Registration

Date _____

Name _____ Sex _____ Date of Birth _____

Address _____
City _____ State _____ Zip Code _____
Home Telephone _____
Phone to confirm appointment _____
E-Mail Address _____
Is it okay to contact you at this email with medical information? Yes _____ No _____
Previous Physician _____
Emergency Contact (other than parents) _____
Phone Number _____

Referred by (who recommended our office to you?) _____

Parents' Names:

_____ Date of Birth _____
Home Address (if different from above) _____
City _____ State _____ Zip Code _____
Home Telephone _____ Work Telephone _____
Cell Phone _____ Marital Status _____
Occupation _____ Employer _____

_____ Date of Birth _____
Home Address (if different from above) _____
City _____ State _____ Zip Code _____
Home Telephone _____ Work Telephone _____
Cell Phone _____ Marital Status _____
Occupation _____ Employer _____

Sitter's name: _____ Phone _____
Is this sitter authorized to make/bring your child to appointments without you? YES NO

Insurance Information

Insurance Carrier Name _____
Address _____
City _____ State _____ Zip Code _____
Telephone Number _____ ID Number _____ Group Number _____
Type of Policy HMO _____ PPO _____ PPC _____ Other _____
Copay Amount _____
Full Name of policy holder _____

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the parent bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance or any other balance not paid by my insurance company. I understand that I am responsible for any costs of patient account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Downtown Pediatrics to release any pertinent information to my insurance company upon request. I also authorize payment directly to Downtown Pediatrics.

Signature _____ Relationship to Patient _____ Date _____

OFFICE USE ONLY
F2/F3 _____ F8 _____ PROVIDER _____ REVIEWED _____