PATIENT REGISTRATION FORM

DATE: ____________________

Patient Name: ____________________ M F DOB: ____________

(as listed with Insurance Company)

Child Lives With:

Parent/Guardian ____________________ DOB: ____________________ Y N

Address ____________________ Home #: ____________________

City/State/Zip ____________________ Cell #: ____________________

Employer ____________________ Work #: ____________________

Email ____________________ SSN: ____________________

Parent/Guardian ____________________ DOB: ____________________ Y N

Address ____________________ Home #: ____________________

City/State/Zip ____________________ Cell #: ____________________

Employer ____________________ Work #: ____________________

Email ____________________ SSN: ____________________

Step-Parent: ____________________ Cell #: ____________________ Y N

Step-Parent: ____________________ Cell #: ____________________ Y N

Emergency Contact: ____________________ Phone: ____________ Relationship: ____________

Referred to us by: ______________________________

Siblings:

Last Name	First Name	Date of Birth

With my signature:

* I authorize the release of all medical information to the insurance companies to process all claims and payment of medical benefits for services.
* I am responsible for the account and agree to pay any amount that is not paid by insurance.
* I understand that the office has employed nurse practitioners to assist in the delivery of medical pediatric care and that I hereby consent to the services of a nurse practitioner for my health care needs. I understand that I can refuse to see the nurse practitioner and request to see my physician.
* I received a copy of the financial policy in the new patient handbook.
* I understand that payments are expected at the time of the visit. I understand that the office is not a party in divorce settlements and that the parent who brings a minor child for care will be responsible for the payment. The office will provide a receipt as proof of payment for reimbursement.

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Signature Date Relationship to patient