

2012 PATIENT REGISTRATION



PATIENT INFORMATION

Date: _____ How did you hear about us? _____
Patient Name (First Middle Last): _____ Social Security Number: _____ Sex: M F
Relationship to Guarantor: _____ Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____ Preferred Telephone: (____) _____
E-Mail Address: _____
Race: _____ Ethnicity: _____ Preferred Language: _____ Mode of contact: Telephone Email

Siblings who visit this office:	Name	Sex (M/F)	DOB (mm/dd/yy)	Social Security #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PARENT INFORMATION

Marital Status of Parents: Married Divorced or Divorce Pending Single (never married)

Mother's Name: _____ Date of Birth: _____ SS #: _____
Contact E-Mail Address: _____ (You may receive periodic email newsletters)
Home Address (Same as Child): _____
City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____
Employer: _____ Cell Phone: (____) _____ Work Phone: (____) _____

Father's Name: _____ Date of Birth: _____ SS #: _____
Contact E-Mail Address: _____ (You may receive periodic email newsletters)
Home Address (Same as Child): _____
City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____
Employer: _____ Cell Phone: (____) _____ Work Phone: (____) _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____
Full Name of Insured: _____ Date of Birth: _____ SS#: _____
Employer: _____ Policy Type: HMO PPO PPC Other: _____
ID Number: _____ Group Number: _____ Co-Pay Amount: _____
Preferred Pharmacy Name: _____ Location/Phone: _____
Previous Physician: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (____) _____
Name: _____ Relationship: _____ Phone: (____) _____

Financial Policy, Assignment Information, and Release of Information

I authorize the release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance to be paid directly to **Pediatric Wizards** or its assignees. I am responsible for any non-covered services, supplies, co-payment or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This is acceptable and assignment will be in force for all future services by practitioners from this office.

Patient/ Parent/ Guardian Signature _____ Date _____ Witness Signature _____ Date _____