FAMILY REGISTRATION.

DATE _____

Parent/Legal Guardian	**Parent/Legal Guardian**
Name: _____	**Name:** _____
HOME PHONE (____) _____	**HOME PHONE** (____) _____
CELL PHONE (____) _____	**CELL PHONE** (____) _____
EMAIL ADDRESS _____	**EMAIL ADDRESS** _____
DATE OF BIRTH _____	**DATE OF BIRTH** _____
WORK PHONE _____	**WORK PHONE** _____
SOCIAL SECURITY# _____	**SOCIAL SECURITY#** _____

Primary Phone Number:_____
This number will be used for initial contact by the office and confirming appts.

All PATIENTS	**BIRTHDATE**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Parents are: _____Married _____Separated _____Divorced _____ OTHER

If divorced, who is the Custodial Parent_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **YES / NO** If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Names of individuals and relationship (other than parents) who may bring in my child/children and be responsible for carrying out the directives given to them by my pediatrician.

Name_____cell phone_____relationship_____

Name _____cell phone_____relationship_____

STATEMENT ADDRESS: Legally the statements must be sent to the parent/guardian who is signing authorization and treatment portion below. (This is not necessarily who is the primary insurance holder.) If other arrangement is requested it must be authorized by other parent/guardian with a signed authorization form.

NAME:_____ Relationship_____

ADDRESS_____

_____

CITY_____STATE_____ ZIP_____

Secondary Address:

NAME:_____ Relationship_____

ADDRESS_____

_____

CITY_____STATE_____ ZIP_____

Insurance Information will be verified via your insurance card copied at each visit. Please make sure we have your most current card copied at all times.

SUBSCRIBER/POLICY HOLDER'S NAME_____

WHO IS COVERED_____ EFFECTIVE DATE_____

Name of Insurance Company_____

PLEASE READ: We will bill your insurance for any PPO we are contracted with. Any copays or balances previously billed are due at the time of your visit.

AUTHORIZATION:

I understand that I will be charged (not my insurance) for canceled appointments unless I give 24 hours notice.
All of the office policies have been provided to me and I understand all policies. I agree to all policies that have been provided to me in writing.

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process insurance claims.

INSURED'S AUTHORIZATION FOR INSURANCE TO PAY YOUR DOCTOR

I authorize and request payment of medical benefits directly to_____(your Doctor's name)

PRIVACY PRACTICES:

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices(HIPPA)

I CERTIFY THAT I AM THE RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE AND THAT I HAVE THE AUTHORITY TO AGREE TO and SIGN ON BEHALF OF THE PATIENT FOR ALL SERVICES RENDERED. I, ALSO, CERTIFY THAT I AM THE FINANCIALLY RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE and THAT I HAVE THE AUTHORITY TO AGREE TO ALL PRACTICE POLICIES AND FINANCIAL POLICIES.

Printed Name _____

Relationship _____

Signature_____ **Date**_____

Family Registration UPDATED

_____ **Sign and Date**

_____ **Sign and Date**

_____ **Sign and Date**

_____ **Sign and Date**

_____ **Sign and Date**

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