KIDS' DOC PEDIATRICS

PATIENT REGISTRATION.

Patient Information: (*Please use full legal name, no nicknames*)

Last Name: _____ First Name: _____ Middle Name: _____

SSN#: _____ DOB: _____ Sex: Male _____ Female _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Emergency Contact Name: _____ Emergency Phone: (_____)_____

Parent/Legal Guardian Information:

(*Use full legal name, no nicknames please*)

Mothers First & Last Name: _____ **DOB:** _____ **SSN#:** _____

Fathers First & Last Name: _____ **DOB:** _____ **SSN#:** _____

Address (if different from above): _____ City/State/Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ E-Mail: _____

Married _____ Divorced _____ Single _____ Siblings: _____

Relationship to patient: Parent ____ Legal Guardian: ____

*** (If you checked Legal Guardian, please present legal documents to front desk)**

Insurance Information

Primary Insurance:

Policy Holder's Name: _____ SSN#: _____ DOB: _____

Relationship to Patient: _____ Employer's Name: _____

Insurance Name: _____ Policy ID#: _____ Group#: _____

Effective Date: _____ Insurance Claim Address & Phone#: _____

Secondary Insurance:

Policy Holder's Name: _____ SSN#: _____ DOB: _____

Relationship to Patient: _____ Employer's Name: _____

Insurance Name: _____ Policy ID#: _____ Group#: _____

Effective Date: _____ Insurance Claim Address & Phone#: _____

Parent/Guardian Name: _____

(Print First & Last Name)

Parent/Guardian Signature: _____ **Date:** _____

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TREATMENT AUTHORIZATION

I, _____,
(Parent/Guardian Print First & Last Name)

Hereby, give permission for:

1. _____, _____
(Authorized Person First & Last Name) (Relationship to patient)

2. _____, _____
(Authorized Person First & Last Name) (Relationship to patient)

to authorize treatment and bring my child and/or children:

1. _____ 2. _____
(Print Child First & Last Name) (Print Child First & Last Name)

3. _____ 4. _____
(Print Child First & Last Name) (Print Child First & Last Name)

to the Doctor's Office for appointment(s).

Should you have any questions, I can be reached at:

Home Phone:_____ **Cell Phone:**_____
(Phone #1) (Phone #2)

Parent/Guardian Signature: _____ **Date:** _____

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FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **DOB**: _____
First Middle Last

I understand and agree that I will be financially responsible for any and all charges for office visit services not paid by my insurance. This includes any Medical services or visit, Preventative exam or Physical, Lab testing, X-ray, EKG, and any other screening service or Diagnostic testing ordered by the Physician or the Physician staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or Physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the Physician or the Physician's Staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the Physician or Provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the Physician or Provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to bring my current insurance card to each office visit. If I fail to Bring my current insurance card to an office visit it will result in rescheduling of the appointment. I understand this and agree.

Appointments

I understand and agree it is my responsibility to call the office **24hrs** before the appointment and Cancel or Reschedule. If I fail to call in to cancel or reschedule my appointment on the third no show incident, I understand I will be dismissed from the practice and a termination letter will be mailed out.

Parent/Guardian Name: _____
(Print First & Last Name)

Parent/Guardian Signature: _____ **Date:** _____