



FAMILY REGISTRATION FORM

PATIENT INFORMATION				
LAST NAME	FIRST NAME	MIDDLE	D.O.B.	S.S.N.

Parent/legal guardian information:

Full name (last, first, middle): _____
Relationship to patient: _____
Address: _____
City, state, zip: _____
Home phone: _____
Date of birth: _____
Social Security number: _____
Employer name: _____
Business phone: _____
E-mail address: _____

Other guardian:

Full name (last, first, middle): _____
Relationship to patient: _____
Address: _____
City, state, and zip: _____
Home phone: _____
Business phone: _____

Insurance information:

Primary insurance company: _____
Subscriber (guarantor) name: _____
Subscriber (guarantor) Social Security number: _____
Group number: _____
ID number: _____
Secondary insurance company: _____
Subscriber (guarantor) name: _____
Subscriber (guarantor) Social Security number: _____
Group number: _____
ID number: _____

Emergency information:

Person to contact in case of emergency: _____
Relationship to patient: _____
Address: _____
City, state, zip: _____
Phone number: _____

Signature-on-File Form

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Assignment of Benefits/Authorization/Notice of Collection Action

I request payment of insurance benefits for all services rendered to me or to my child/children to be made on our behalf to Premier Pediatrics. I authorize Premier Pediatrics to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand I am responsible to pay certain amounts due. These amounts may include annual deductibles, copayments, charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action (e.g. late fees, collection agency, court, or attorney costs). Please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing.

The undersigned certifies that each has read and understands the above terms and conditions.

Patient name (please print)

X

Patient signature Date

X

Patient's agent representative and guarantor signature Date