PATIENT REGISTRATION FORM

Fill out COMPLETELY; all previous forms will be discarded.

PATIENT INFORMATION

1	NAME (Last, First, MI)	DOB	SEX M F	Home Phone
2	NAME (Last, First, MI)	DOB	SEX M F	Cell Phone (mom)
3	NAME (Last, First, MI)	DOB	SEX M F	Cell Phone (dad)
4	NAME (Last, First, MI)	DOB	SEX M F	Alternate Phone
5	NAME (Last, First, MI)	DOB	SEX M F	
	Address	City	State	Zip
	Person to notify in case of emergency (NOT living with patient)	Relationship to patient		Phone

Fathers name	SSN	Mothers name	SSN

INSURANCE INFORMATION

Name of Insurance (i.e. Blue Cross, PPOM, BCN)		Employer		
Name of Insurance Holder (i.e. John Doe)	Relationship to patient		DOB	*SSN*
Address (if different)	City	State	ZIP	Phone

DO YOU HAVE ADDITIONAL INSURANCE? If yes, please complete the following.

Name of Insurance (i.e. Blue Cross, PPOM, BCN)		Employer		
Name of Insurance Holder (i.e. John Doe)	Relationship to patient		DOB	*SSN*
Address (if different)	City	State	ZIP	Phone

AUTHORIZATION:

I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any; social services records, if any, including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any; to my insurance company for the purpose of payment of bill and to my health care provider for continuity of care. I authorize my insurance company to pay directly to the provider the amount due for medical care. **IN ADDITION, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AMOUNTS THAT ARE NOT COVERED BY MY INSURANCE AND I AGREE WITH ALL PATIENT PAYMENT POLICIES AT PREMIERE PEDIATRICS.**

Signature	Date	Witness
Signature	Date	Witness
Signature	Date	Witness

*** PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED ***