Premiere Pediatrics Registration Form

PATIENTS INFORMATION

(Please list all children we will be caring for)

Last Name	First Name	MI	M/ F	DOB	Chart #
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PARENTS INFORMATION

Home Street Address		City	State Zip	Phone ( ) -
Father's Name	Occupation/ Employer	DOB / /	CELL PHONE ( ) -	SSN
Mother's Name	Occupation/ Employer	DOB / /	CELL PHONE ( ) -	SSN
Guardian's Name	Occupation/ Employer	DOB / /	CELL PHONE ( ) -	SSN
Emergency Contact (Other than Parents)		Relationship		Phone ( ) -

INSURANCE & BILLING INFORMATION

Person Financially Responsible: ☐ Father ☐ Mother ☐ Other Relationship:

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Subscriber's Name	Subscriber's Name
Insurance ID	Insurance ID
Group #	Group #
Policy Holders DOB	**Policy Holders DOB**
Relationship to Patient	**Relationship to Patient**

PAYMENT REQUIRED AT TIME OF SERVICE- UNLESS PRIOR ARRANGEMENT HAS BEEN MADE

HIPPA STATEMENT: We protect our patients' information and records that we have about their health and services received in our office. We must have a written and signed consent in order to disclose your health information for the purpose of treatment, the payment of your bills, appointment reminders etc. I understand that I may revoke authorization or change those listed at any time in writing. Notice of privacy practice form available upon request.

Signature____________________________________Date____________

Please list any family members or persons, if any, whom may be inform about general condition, diagnosis, medication refills, and appointments.

Name(s)____

Financial Responsibility: I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by MY insurance and that I will pay any copays on the date of service unless other arrangements are made.

Signature of Parent______________________________Date____________