

PATIENT REGISTRATION FORM

Fill out COMPLETELY; all previous forms will be discarded.

| PATIENT INFORMATION | | | |
|---|------------------------|-------------------------|------------|
| 1 | NAME (Last, First, MI) | DOB | SEX M F |
| 2 | NAME (Last, First, MI) | DOB | SEX M F |
| 3 | NAME (Last, First, MI) | DOB | SEX M F |
| 4 | NAME (Last, First, MI) | DOB | SEX M F |
| 5 | NAME (Last, First, MI) | DOB | SEX M F |
| *Address* | | City | State |
| 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 ***