Registration Form

Patient's Name (Last, First, M.I.) Sex (M/F) Date of Birth

_____

_____

_____

Home Address_____ Apt#_____
City _____ State _____ Zip Code _____
Ethnicity (Race) _____ Preferred Language _____

Responsible Party

Responsible party is the individual who agrees to accept financial responsibility for the payment of all services performed at Memorial City Pediatrics. This individual may not necessarily be the insurance card holder. The Responsible Party must read and sign below.

First Name_____ Last Name _____ DOB _____
Occupation _____ Cell Phone (____)_____
Employer Name _____ Work Phone (____)_____Ext_____
Employer Address _____

Parent's Marital Status _____ Child resides with (check) _____ _____ ____ ____
both parents mother father other

Authorized Individual/Emergency Contact

Parent _____ DOB _____ Parent _____ DOB _____

Name_____Phone#_____Relationship to Patient_____

Name_____Phone#_____Relationship to Patient_____

It is the policy of Memorial City Pediatrics that you must authorize family members and others who make appointments and accompany your child(ren) to their appointments. Therefore, the following other individuals (other than parents) are authorized to act in your place with Respect to any and all medical matters. Please not that as we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

Primary Insurance (Person who holds coverage)

Insurance Company _____ ID # _____ Group Name or # _____
Policy Effective Date _____ Co-Pay Amount: _____
Insured's Name __ _____ Social Security # _____ DOB _____
Relationship to Patient _____
Dose the patient have a secondary Insurance? Yes-[] No-[] If yes please list_____

Insurance Assignment & Release of Information

- I authorize the release of my child's any medical information necessary to process insurance claims.
- I authorize the release of payment of medical benefits to my child's provider.
- I have received notice of Memorial City Pediatrics Privacy Practice Policy.
- I have read Memorial City Pediatrics Office Policy and agree to the terms listed.
- I understand that I am financially responsible for any deductible & coinsurance fees, and charges for non-covered services. Unless I am a member of an insurance organization that Memorial City Pediatrics is a contracted provider, all charges are due at the time that services are rendered.

_____ _____
Guarantor's Signature Date