

PATIENT REGISTRATION

Date _____ Primary Physician _____
Child's Name _____ Sex M _____ F _____ Birthdate _____

PARENT REGISTRATION

Mother's Name _____
Last First MI
SSN Birthdate

Home Address _____
City State Zip

Home Phone _____
Work Phone _____
Occupation _____
Employer _____
Address _____

City State Zip

Emergency Contact: _____
Name Telephone Number Relationship to Patient

Father's Name _____
Last First MI
SSN Birthdate

Home Address _____
City State Zip

Home Phone _____
Work Phone _____
Occupation _____
Employer _____
Address _____

City State Zip

INSURANCE INFORMATION

THIS SECTION MUST BE COMPLETED IN FULL TO BILL INSURANCE COMPANIES

PRIMARY INSURANCE - Copay _____
Insurance Plan _____
Name of Insured _____
ID # _____
Group # _____
Date Effective _____
HMO _____ PPO _____ Other _____

SECONDARY INSURANCE - Copay _____
Insurance Plan _____
Name of Insured _____
ID # _____
Group # _____
Date Effective _____
HMO _____ PPO _____ Other _____

PATIENT INFORMATION

PLEASE LIST EACH CHILD FOR WHOM WE WILL PROVIDE CARE

NAME	SEX	BIRTHDATE	SSN
Last First MI	M/F	Mo/Day/Year	#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please read and initial or sign as indicated:

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private and any other health plan to Fenton Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Initials _____

Consent to Treatment: I hereby authorize Fenton Pediatrics or whomever they may designate, to administer treatment to the afore named children.

Initials _____

Acknowledgement of Receipt of Notice of Privacy Practices: I hereby acknowledge that I have been provided with Fenton Pediatrics' Notice of Privacy Practices, which provides a description of how the practice might use and disclose personal health information for the purposes of treatment, payment and healthcare operations.

Initials _____

As the parent of _____, I give Fenton Pediatrics, permission to treat and/or immunize my child in the event that I am unable to accompany him/her to the office. I understand that in all situations, the doctors prefer to have a parent present to obtain a medical history and to give permission for treatment or vaccinations. By sending my child with a caregiver or by sending my adolescent child alone, I am giving consent to any medical procedure the physician deems necessary.

Signature _____

Relationship to Patient _____