Pediatric Center of Round Rock
Caring for the future by taking care of the present

Patient Registration Form

Thank you for choosing the Pediatric Center of Round Rock for the care of your children. Please assist us in collecting the appropriate demographic information about your family to assist us in filing your insurance claims efficiently.

Name: _____ **DOB** _____ **M**____**F** ____

How were you referred to our office? [ ] Friend / Family / Coworker [ ] Internet [ ] Phonebook [ ] Magazine
_____ [ ] Insurance Company [ ] TV [ ] ZOCDOC [ ] News paper
[ ] MD _____ **[ ] Other** _____

Sibling's Names: First and Last

_____	**DOB**	_____	**M**	**F**
_____	**DOB**	_____	**M**	**F**
_____	**DOB**	_____	**M**	**F**
_____	**DOB**	_____	**M**	**F**

Race Ethnicity:	**[] White, Non-Hispanic [] Black, Non-Hispanic [] Hispanic [] Asian** **[] Native American** **[] Native Hawaiian and Other Pacific Islander [] Other:**

Child's Address _____
Apt #: _____ **City:** _____ **St:** _____ **Zip:** _____
Home Phone Number: _____**Parents: Married** ___ **Divorced** ___ **Separated** ___
Single ___ **Child lives with: Mother** ___ **Father** ___ **Other :** **Name:**
_____ **Relationship:** _____

Mother _____	**Father** _____
Employer _____	**Employer** _____
License # _____	**License #** _____
Cell # _____	**Cell #** _____
Work # _____	**Work #** _____
E-Mail _____	**E-Mail** _____

[ ] Self-Pay [ ] Insurance coverage
PRIMARY INSURANCE _____
Claims mailing address _____
Member ID # _____ **Group #** _____
SS # _____ **Employer** _____
Insured Parent _____ **DOB** _____

Pharmacy to send Prescriptions:

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Person responsible for payment of account _____

Address _____

Apt #: _____ **City:** _____ **St:** _____ **Zip:** _____

Phone # _____ **Email** _____

Relationship _____

Are all of the children listed above covered by the same policy? Y N

SECONDARY INSURANCE _____

Claims mailing address _____

Member ID # _____ **Group #** _____

SS # _____ **Employer** _____

Insured Parent _____ **DOB** _____

Office Use:
Reviewed by _____ *Ins verified by* _____ *Updated by* _____

Emergency Contact Information (someone other than parents)

Name: _____ **Relationship** _____ **Phone #** _____
Name: _____ **Relationship** _____ **Phone #** _____

Please list the person(s) that you authorize to accompany and give consent for treatment to the child at appointment time, other than a parent or step-parent. If at any time you wish to terminate this authorization you must notify our office in writing of necessary changes.

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

I understand that if any of the above information changes that it is my responsibility to provide PCRR with a written update of information indicating all necessary changes.

I understand that my primary insurance company will be billed for me but that all co-pays, co-insurance, non-covered items and deductible amounts are due at the time of service. I also understand that if my insurance company denies a charge for any reason, I will be billed and ultimately responsible for that charge. In addition, if a claim is disputed by the insurance company for any reason, and payment has not been made in a timely manner, I will be responsible for the payment of the charges until the dispute has been resolved and the insurance company makes payment on the charges in question. Lastly, I authorize insurance benefits to be paid directly to the physician and the release of any medical records that may be required by the insurance company in order to pay out those benefits. This assignment of benefits is irrevocable and a photo static copy shall be considered as legal and binding as the original. In event of default for any reason, parent/guardian is responsible for any and all attorney fees, collection fees and all courts costs.

Patient Name:_____ **Print Responsible Party name** _____
Signature _____ **Date** _____

Relationship to patient [ ] Mother [ ] Father [ ] Other _____