Kiddie Health Pediatrics, LLC **Melanie M. Garcia, M.D., F.A.A.P.**

PATIENT REGISTRATION

Patient's Name: _____ D.O.B_____ Sex: ( ) Male ( ) Female

Social Security #: _____ Address _____

City/State: _____ Zip Code _____ Telephone _____

Cellphone _____

Mother's Name: _____ Father's Name: _____

Mother's DOB: _____ Father's DOB: _____

Mother's SSN: _____ Father's SSN: _____

Mother's Employer: _____ Father's Employer: _____

Emergency Contact Person: _____

Telephone No. : _____ Relationship: _____

Insurance Information:
Primary Insurance: _____ COPAY : _____

Member Insurance ID #: _____ GROUP#: _____

Policy Holder's Name: _____ Relationship: _____

Address on back of card: _____

Phone # on back of card: _____

Secondary Insurance: _____ COPAY: _____

Member Insurance ID #: _____ GROUP#: _____

Policy Holder's Name: _____ Relationship: _____

Address on back of card: _____

Phone # on back of card: _____

Person Responsible for Payment (if other than patient):

Name: _____ Relationship: _____
Address (if not the same): _____
Telephone #: _____ Social Security #: _____
Employer: _____ Work Phone #: _____
Referred by: _____

"I verify the accuracy of the above information and authorize to process any claims. I understand that I am financially responsible for all charges whether or not paid by insurance. I request payment of this claim and if payer accepts assignment, I authorize payment directly to the Physician."

Parent or Authorized Signature: _____ **Date**: _____