Elite Pediatrics - Patient Registration

Patient Information

Patient Name _____ DOB ____/____/____ Sex: ( ) M ( ) F
Patient Name _____ DOB ____/____/____ Sex: ( ) M ( ) F
Patient Name _____ DOB ____/____/____ Sex: ( ) M ( ) F
Physical Address _____
City_____ State _____ Zip Code_____ Home # (____) _____
Pharmacy Name: _____ Location: _____ Number: _____
How did you hear about us? _____

Mother's Employer Information

Marital Status: ( )S ( )M ( )D ( )Sep ( )W DOB _____/_____/_____
Mother's Name _____ SSN _____
Wk Phone (____) _____ Cell (_____) _____ Alternate (____) _____
Employer Name _____
Employer Address _____City/State_____ Zip Code_____
Driver's License #_____ Occupation _____

Father's Employer Information

Marital Status: ( )S ( )M ( )D ( )Sep ( )W DOB _____/_____/_____
Custodial Parent (Y/N) If not, then whom? _____
Father's Name _____ SSN _____
Wk Phone (____) _____ Cell (_____) _____ Alternate (____) _____
Employer Name _____
Employer Address _____City/State_____ Zip Code_____
Driver's License #_____ Occupation _____

Person To Contact In Case Of Emergency (OTHER THAN PARENT)

Name _____Relationship _____
Address _____City_____State_____Zip_____
Home Phone ( )_____ Cell ( )_____

Insurance

Primary Insurance Name/Address_____
Subcriber's Name _____ Effective Date _____/_____/_____
ID # _____ Plan Type _____ Group # _____
Secondary Insurance Name/Address_____
Subcriber's Name _____ Effective Date _____/_____/_____
ID # _____ Plan Type _____ Group # _____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process any claims. I permit a copy of this authorization to be used in place of an original. I hereby authorize Elite Pediatrics to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Elite Pediatrics.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to this medical group to apply to my account, should a balance exist.

_____ _____/_____/_____
Parent/Guardian Signature Date