REGISTRATION FORM

PEDIATRIC PRACTICE, PC

8600 Rolling Rd. Suite 100, Manassas, VA 20110 / 703-361-3870
4080 Lafayette Center Dr. Suite 230A, Chantilly, VA 20151 / 571-321-1086

PATIENT'S INFORMATION	**PRIMARY INSURANCE INFORMATION**
Name	Name
Date Of Birth	Address
Phone	
Address	Phone
	ID
EMERGENCY CONTACT	Group
Phone	
Parent/Guardian	**SECONDARY INSURANCE**
Name	Name
Date Of Birth	Address
Social Security Number	
Address	Phone
	ID
Phone	Group
OTHER PARENT/GUARDIAN INFORMATION	
Name	Social Security
Date Of Birth	Address

POLICY Patients who carry health insurance must remember that the prof. services are charges to the patient and not to the insurance Company Your insurance Company has no obligation to pay for services rendered in this office, its obligation to you, the policyholder. Even though the claim is filed to the insurance Company on your behalf, you are responsible for the payment on the account. This office cannot accept responsibility for checking late insurance payments or for negotiating settlement on your behalf. **Any balance is the patient's/parents' responsibility.**

AUTHORIZATION I hereby authorize Pediatric Practice, PC to apply for benefits on my behalf services rendered. I request payment to be made directly to the above-named practice/provider. I understand & agree that I am personally responsible for all the fees not paid by the insurance company.

I certify the information with regard to my insurance is correct & authorize the release of any necessary information, including medical information for this or any other related claim to the above-named billing company. I permit a copy of this authorization to be used in place of the original; this could be revoked by either the above or me in writing, ant time. I hereby authorize the release of my records to and discussion of my care with my treating physician & other health care providers.

Signature	Name	Date