Patient Registration Form

Patient Name: _____ Date of Birth: _____ Sex: M or F

Relationship to Guarantor: _____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Home Telephone: _____

	Name (First and Last)	**Sex (M/F)**	**DOB (mm/dd/yy)**	**Social Security #**
Siblings who visit this office				

Parent / Guardian Information

Marital Status of Parents: ___Married ___ Divorced or Divorce Pending ___Single (never married)

Mother's Last Name: _____ First Name: _____

DOB: _____ SSN: _____ Home Ph _____ Cell Ph _____ Work Ph _____

Employer: _____ Occupation: _____

Father's Last Name: _____ First Name: _____

DOB: _____ SSN: _____ Home Ph _____ Cell Ph _____ Work Ph _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship _____ Phone: _____ Cell: _____

Next of Kin: _____Relationship _____ Phone: _____ Cell: _____
Not living at address above

Contact Preference: _____Home Phone _____ Cell Phone _____ Work Phone

E-Mail:_____

How did you hear about us?

Patient Name: _____ DOB:_____

Guarantor / Insurance Information

Guarantor's Last Name: _____ First Name: _____

Guarantor's DOB: _____ Guarantor's SSN: _____ Guarantor's Phone: _____

Guarantor's Address: _____ City: _____ Zip Code: _____

If different from patient's

Optional Guarantor Last Name: _____ Guarantor First Name: _____

Guarantor's DOB: _____ Guarantor's SSN: _____ Guarantor's Phone: _____

Guarantor's Address: _____ City: _____ Zip Code: _____

Insurance Policy Information

Primary Insurance: _____ Effective Date: _____ Co-Pay Amount: _____

Address: _____ City: _____ State: ___ Zip: _____ Phone: _____

Full Name of Insured: _____ DOB: _____ SS# _____

Employer: _____ Policy Type: HMO PPO PPC POS Other: _____

If you belong to an HMO, do you also have other Group Insurance Coverage: Yes Other

Preferred Pharmacy Name: _____ Phone: _____

Address/Street: _____ City: _____

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to **PEDIATRIC CARE OF FOUR CORNERS, PLLC** to release any pertinent information to my insurance company upon request, and I also authorize payment directly to **PEDIATRIC CARE OF FOUR CORNERS, PLLC**. Additionally, I authorize **PEDIATRIC CARE OF FOUR CORNERS, PLLC** to obtain medication history for this patient. A photocopy of this authorization shall be considered as effective and valid as the original.

_____

Parent/Guardian Signature Date Witness Signature Date

**Return this form to a staff member before leaving the office. Thank you. **