



Family/Patient Registration Form

2004

Date:
Patient Name:
Date of Birth:
Home Address:
City:
State:
Zip Code:
Next of kin (not living at address listed above):
Relationship:
Address:

Please list all children who will be patients:

Table with 4 columns: Child's Full Name, Child's Date of Birth, Sex, Insurance ID number. Contains 6 rows for listing children.

Person responsible for bill (guarantor):
Relationship to patient:

PARENT/GUARDIAN/GUARANTOR INFORMATION

Name:
Date of Birth:
Relationship to child:
Home Address (if different):
City:
State:
Zip Code:
Home Telephone:
Work Telephone:
Cell Phone:
Employer:
Employer Address:
Social Security Number:
Marital Status:

Name:
Date of Birth:
Relationship to child:
Home Address (if different):
City:
State:
Zip Code:
Home Telephone:
Work Telephone:
Cell Phone:
Employer:
Employer Address:
Social Security Number:
Marital Status:

INSURANCE INFORMATION

Primary Insurance Name:
Effective Date:
Address:
City:
State:
Zip Code:
Telephone Number:
ID Number:
Group Number:
Full Name of Insured:
Policy Type:
Other:
If you belong to an HMO, do you also have other Group Insurance Coverage?
Yes No
Co-Pay Amount:

How did you hear about us, or who referred you to us?
Previous Physician:

NOTIFY IN CASE OF EMERGENCY

Name:
Relationship:
Phone: ()

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Covenant Care Pediatrics to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Covenant Care Pediatrics. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature:
Date:
Witness: