2012 PATIENT REGISTRATION

Pediatric Wizards
The Magic of Caring

PATIENT INFORMATION

Date: _____ How did you hear about us? _____

Patient Name (First Middle Last): _____ Social Security Number: _____ Sex: ☐ M ☐ F

Relationship to Guarantor: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Preferred Telephone: (_____) _____

E-Mail Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____ Mode of contact: ☐ Telephone ☐ Email

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

PARENT INFORMATION

Marital Status of Parents: ☐ **Married** ☐ **Divorced or Divorce Pending** ☐ **Single (never married)**

Mother's Name: _____ Date of Birth: _____ SS #: _____

Contact E-Mail Address: _____ (You may receive periodic email newsletters)

Home Address (☐ Same as Child): _____

City: _____ State: _____ Zip Code: _____ Home Phone: (___) _____

Employer: _____ Cell Phone: (___) _____ Work Phone: (___) _____

Father's Name: _____ Date of Birth: _____ SS #: _____

Contact E-Mail Address: _____ (You may receive periodic email newsletters)

Home Address (☐ Same as Child): _____

City: _____ State: _____ Zip Code: _____ Home Phone: (___) _____

Employer: _____ Cell Phone: (___) _____ Work Phone: (___) _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____

Full Name of Insured: _____ Date of Birth: _____ SS#: _____

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

ID Number: _____ Group Number: _____ Co-Pay Amount: _____

Preferred Pharmacy Name: _____ Location/Phone: _____

Previous Physician: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Financial Policy, Assignment Information, and Release of Information

I authorize the release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance to be paid directly to **Pediatric Wizards** or its assignees. I am responsible for any non-covered services, supplies, co-payment or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This is acceptable and assignment will be in force for all future services by practitioners from this office.

Patient/ Parent/ Guardian Signature **Date** **Witness Signature** **Date**