

Patient Registration

Patient Information

Date __/__/__ Chart No.

Patient _____ Sex: M F DoB __/__/__ SS# _____
Mother/Guardian _____ DoB __/__/__ SS# _____
Address _____ Home Phone _____
City/State/Zip _____ Occupation _____
Employer _____ Work Phone _____

Father/Guardian _____ DoB __/__/__ SS# _____
Address _____ Home Phone _____
City/State/Zip _____ Occupation _____
Employer _____ Work Phone _____

Sibling _____ Sex: M F DoB __/__/__ Sibling _____ Sex: M F DoB __/__/__
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Sibling _____ Sex: M F DoB __/__/__ Sibling _____ Sex: M F DoB __/__/__

Children live with: Mother Father Guardian _____

Emergency contact person _____ Relationship _____ Phone _____

Who referred you to our office? _____

Insurance Information

Primary _____ Claims Address _____
Policy # _____ Group # _____ Co-payment \$ _____
Name of Insured _____ Relationship _____

Primary _____ Claims Address _____
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Name of Insured _____ Relationship _____

Medicaid/Champus/Other _____ Current Card # _____
Physician Listed on Card _____ Phone _____

Authorization of Treatment and Assignment of Benefit

I authorize Frederic Pediatric Associations to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Frederic Pediatric Associates for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following:

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature _____ Relationship _____ Date _____