



**PATIENT REGISTRATION FORM**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFO**

**PATIENT Full Legal Name** \_\_\_\_\_ **SS #** \_\_\_\_\_

Date of birth \_\_\_\_\_ Home Address \_\_\_\_\_

\_\_\_\_\_ **City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Ethnicity:**  Non-Hispanic  Hispanic  Not specified. **Preferred language:** \_\_\_\_\_

**Race:**  African or African American.  Asian or Asian American.  Caucasian or European American.  
 Native American or Native Alaskan.  Native Hawaiian or other Pacific Islander.  Other race

**PARENT/ GUARDIAN INFO**

**Parent/Guardian Name** \_\_\_\_\_ **Relationship to Child** \_\_\_\_\_

Birth Date \_\_\_\_\_ SS # \_\_\_\_\_

Home Address \_\_\_\_\_

Phone numbers (H) \_\_\_\_\_ (Cell) \_\_\_\_\_ (W) \_\_\_\_\_

**INSURANCE INFO/ RESPONSIBLE PARTY**

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_

Child's ID # \_\_\_\_\_ Insurance policy holder's name \_\_\_\_\_

SS # \_\_\_\_\_ Relationship to child \_\_\_\_\_

**EMERGENCY CONTACT INFO (not living with patient)**

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Ph #** \_\_\_\_\_

I hereby assign the benefits from any insurance or third party to PEDIATRIC POD for medical services provided to my child. I understand that PEDIATRIC POD has the right to decline or accept assignment of such benefits. If these benefits are not assigned to PEDIATRIC POD, I agree to forward to the practice, upon receipt, any insurance or third-party payments I receive for services rendered to me. I authorize the release of any medical information needed to determine the benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_