

# PEDIATRIC PATIENT REGISTRATION FORM

Today's Date: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

## PATIENT INFORMATION: (Please use full legal name, no nicknames please)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Address: \_\_\_\_\_ SS# \_\_\_\_\_

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

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Female [ ] Male [ ]

Emergency Contact Name: \_\_\_\_\_ Emerg Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## PARENT INFORMATION: (List person or Insured name responsible for bill – use full legal name, no nicknames please)

\*\*Person responsible for Bill: \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

Other person who can give consent if parents cannot be reached (MUST BE A RELATIVE), please provide name and relationship:

\*\*Mom's First & Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_ Mother's Work Phone # \_\_\_\_\_

\*\*Dad's First & Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Married \_\_\_\_\_ Divorced: \_\_\_\_\_ Single: \_\_\_\_\_ Mom's Cell: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Dad's Cell: \_\_\_\_\_ Dad's Work Phone # \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Please provide name of patients siblings: \_\_\_\_\_

## INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

### PRIMARY INSURANCE:

\*\*Policy Holder's name : \_\_\_\_\_ Insurance Name: \_\_\_\_\_

\*\*Policy Holder's Social Security #: \_\_\_\_\_ \*\*Policy Holder's DOB: \_\_\_\_\_

\*\*Policy / ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Eff Date: \_\_\_\_\_

Insurance Claims Address & Phone: \_\_\_\_\_

### SECONDARY INSURANCE:

\*\*Policy Holder's name : \_\_\_\_\_ Insurance Name: \_\_\_\_\_

\*\*Policy Holder's Social Security #: \_\_\_\_\_ \*\*Policy Holder's DOB: \_\_\_\_\_

\*\*Policy / ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Eff Date: \_\_\_\_\_

Insurance Claims Address & Phone: \_\_\_\_\_

\*\* Required Fields Please attach a copy of patient's insurance card in addition to completing all information on this form.

*Please read and sign back of form.*

**MEDICALEDGE HEALTHCARE GROUP  
PATIENT REGISTRATION FORM  
DISCLOSURES & CONSENTS**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
First Name M.I. Last Name

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

**MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:**

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MedicalEdge Healthcare Group or the physician on my behalf.

**AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**

I certify that I have received and read a copy of the MedicalEdge Healthcare Group Patient Information Privacy Policy. I hereby authorize MedicalEdge Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

**AUTHORIZATION TO MAIL, CALL OR E-MAIL:**

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MedicalEdge Healthcare Group to that effect in writing.

**LAB/X-RAY/DIAGNOSTIC SERVICES:**

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

**CONSENT TO TREATMENT:**

I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**GUARANTOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(If different from patient)

**GUARANTOR NAME (Please Print):** \_\_\_\_\_