

Pediatrics Plus*pc Registration Form

Date _____

Parent or Guardian #1 _____		
Birth Date _____	Social Security # _____	
Employer _____	Occupation _____	Work Phone _____
Home Address _____		Home Phone _____
City, State, Zip _____		Cell Phone _____
Parent or Guardian #2 _____		
Birth Date _____	Social Security # _____	
Employer _____	Occupation _____	Work Phone _____
Home Address _____		Home Phone _____
City, State, Zip _____		Cell Phone _____
E-Mail Address _____		
Would you like to receive office e-mail announcements? Yes ___ No ___		
What would be the best phone number to confirm appointments? _____		
Is it acceptable for us to call the workplace? Yes ___ No ___		

Insurance Information

Primary Insurance _____	
Subscriber's Name _____	Date of Birth _____
Secondary Insurance _____	
Subscriber's Name _____	Date of Birth _____

Children's Information

Name/Sex	Birth Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Information

Are you a new patient? Yes ___ No ___
If yes, who were you referred by _____
Previous Pediatrician _____

Release of Information

I authorize my health care provider, or their representative to release information relating to an illness, injury, diagnosis, care or treatment to my insurance company, health plan, Medicare, Medicaid, or third party payor or their agents, contractors, subcontractors or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records and medical information, including: psychiatric, psychological, nervous/mental, and substance abuse (e.g. alcohol and drug abuse). I understand that the reason for furnishing such information may include the following: for use in medical, financial or physician auditing, or such other auditing, as may be legally required, for utilization and/or quality of care review and assessment and for determining available health benefits and coverage.

Parent/Patient Signature _____ **Date** _____

I authorize direct payment of medical benefits to Pediatrics Plus* pc for healthcare services my child(ren) receives. I recognize that I am legally responsible for all charges not covered by my health plan, as well as all co pays, co-insurances and deductibles.

Parent/Patient Signature _____ **Date** _____