Patient Registration

Child 1: Name: _____ **DOB:** _____/_____/_____ **Sex: M/F**

Child 2: Name: _____ **DOB:** _____/_____/_____ **Sex: M/F**

Child 3: Name: _____ **DOB:** _____/_____/_____ **Sex: M/F**

Address:_____ City,State,Zip_____

Home Phone: (_____) _____-_____ **Primary Email**: _____

Parent/Guardian 1:

Name: _____ Date of Birth: _____ / _____ / _____ Relationship to Patient: _____

Home Phone: (_____) _____ -_____ Cell Phone: (_____) _____ -_____ Work Phone: (_____) _____ -_____

Email: _____ Occupation:_____

Parent/Guardian 2:

Name: _____ Date of Birth: _____ /_____ / _____ Relationship to Patient: _____

Home Phone: (_____) _____ -_____ Cell Phone: (_____) _____ -_____ Work Phone: (_____) _____ -_____

Email: _____ Occupation: _____

How would you ideally prefer to be contacted regarding the following (circle one)

Medical Information: Home Phone / Work Phone / Cell Phone / Primary Email / Secondary Email

Appointment Reminders: Home Phone / Work Phone / Cell Phone / Primary Email / Secondary Email

Insurance Company:_____Primary Policy Holder(circle one): Mother/Father/Other_____

Holder's Name:_____Policy Holder's DOB: _____/_____ /_____Social Security #:_____-_____-_____

Insurance ID: _____Group ID: _____ Effective Date:_____

If parents are divorced or separated please fill out this section:

Who has custody? Name:_____ Relationship to Patient:_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Emergency Contact (other than parents):

Name:_____ Relationship to Patient:_____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Pharmacy:_____ Phone: (_____) _____ -_____ Address:_____

Financial Policy-By signing below, you accept financial responsibility for all services rendered on your child's behalf whether or not you are present on the date of service. Although another guardian or adult may provide health insurance for the patient, As the parent or legal guardian of the patient listed above you are still responsible for all remaining balances. **Consent for Treatment-** As the parent or legal guardian of the patient listed above, I do hereby consent to the performance of routine diagnostic procedures and/or medical treatment as deemed necessary or advisable by my child's physician(s) at Bidabadi Pediatrics. I hereby authorize Bidabadi Pediatrics to apply for benefits on my child's behalf for all services rendered. I certify that the information I have provided regarding my child's insurance coverage is correct. I further authorize the release of any and all information necessary for my child's insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to Bidabadi Pediatrics on my child's behalf. I have read and agree to the financial policies stated above. I understand that I am ultimately responsible for the balance on my child's account for all services rendered.

(Parent/Guardian Signature) (Print Parent/Guardian Name) (Date)