



# VILLAGE PEDIATRICS PATIENT REGISTRATION FORM

FILE CHARGES TO:  HEALTH INSURANCE  SELF PAY

HOME PHONE NUMBER (INCLUDING AREA CODE) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NO POST OFFICE BOXES PLEASE

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Which of our doctors do your children see? \_\_\_\_\_

### LIST ALL CHILDREN HERE THAT ARE PATIENTS OF VILLAGE PEDIATRICS

	FIRST NAME	MIDDLE	LAST NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
1.	_____	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
2.	_____	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
3.	_____	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
4.	_____	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
5.	_____	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

### MOTHER'S INFORMATION

MOTHER'S NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ DAY PHONE NUMBER: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ CELL PHONE NUMBER \_\_\_\_\_

EMAIL ADDRESS (IF YOU WISH TO PROVIDE) \_\_\_\_\_

### FATHER'S INFORMATION

FATHER'S NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DAY PHONE NUMBER: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ CELL PHONE NUMBER \_\_\_\_\_

EMAIL ADDRESS (IF YOU WISH TO PROVIDE) \_\_\_\_\_

**GUARDIAN INFORMATION (ONLY IF OTHER THAN PARENTS)**

GUARDIAN'S NAME \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_ DAY PHONE NUMBER: \_\_\_\_\_  
EMPLOYER NAME: \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ CELL PHONE NUMBER \_\_\_\_\_  
EMAIL ADDRESS (IF YOU WISH TO PROVIDE) \_\_\_\_\_

**INSURANCE INFORMATION**

**\*\*\*\*\*YOU MUST PROVIDE YOUR INSURANCE CARD(S) AND PHOTO ID TO COPY \*\*\*\*\***

PRIMARY INSURANCE: \_\_\_\_\_  
INSURED NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
EFFECTIVE DATE OF COVERAGE \_\_\_\_\_  
ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_  
CLAIMS MAILING ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_  
INSURED NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
EFFECTIVE DATE OF COVERAGE \_\_\_\_\_  
ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT**

I hereby give authorization for payment of insurance benefits to be made directly to Village Pediatrics. I understand that I am financially responsible for all the charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; and agree that a photocopy of this agreement shall be as valid as original.

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION AGREEMENT**

I authorize the release of my medical records as needed to any physician, facility or other provider of services that Village Pediatrics asks to participate in my medical treatment.

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**CONSENT TO TREAT**

I, the legal guardian/parent, consent for \_\_\_\_\_ to receive medical evaluation and treatment at Village Pediatrics.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_