PREMIERE PEDIATRICS REGISTRATION FORM

Circle your Medical Provider: Dr. Fox, Dr. Fields, Dr. Ellis, Glen, Jake, Sarah, Ginger, and Blakeley

Patient (child) _____
(Last) (First) (Middle)

Date of Birth: _____ Sex: M F Race_____ Childs SS#_____

Childs Place of Residence_____
(Street or PO Box)

☐**Mailing address different** _____
(City) (State) (Zip code)

Your Preferred Pharmacy_____

Child Lives with (please circle): Mother Father Grandmother Grandfather other_____

Mothers name: _____Date of Birth_____

SS#_____ Employer: _____ Work #_____
(Required)

Mothers home #_____ Mothers Cell #_____

Mothers mailing address: _____
(Street of PO Box)

_____
(City) (State) (Zip code)

Fathers name: _____ Date of Birth_____

SS#_____ Employer: _____ Work #_____
(Required)

Father's home #_____ Father's Cell #_____

Father's mailing address: _____
(Street of PO Box)

_____
(City) (State) (Zip code)

Insurance Company_____

Person carrying insurance_____ Relation to patient_____

Carriers SS# _____Carrier's Date of Birth_____
(Required) (Required)

Siblings seen in this office: _____

EMERGENCY CONTACTS (not listed above):

Name: _____ Relationship to patient: _____ Phone: _____

PATIENT'S FULL NAME: _____ BIRTH DATE _____

PRIMARY INSURANCE:

Name of Insurance Company: _____ Policy# _____

Who carries the insurance? _____ Date of Birth _____

Carrier's SS# _____ Relationship to patient: _____

Phone: _____

SECONDARY INSURANCE: (if applicable)

Name of Insurance Company: _____ Policy# _____

Who carries the insurance? _____ Date of Birth _____

Carrier's SS# _____ Relationship to patient: _____

Phone: _____

PAYMENT IS DUE AT THE TIME OF SERVICE. THE PERSON WHO BRINGS THE CHILD IN FOR TREATMENT IS DIRECTLY RESPONSIBLE FOR PAYMENT. This information is true to the best of my knowledge. I have reviewed the Notice of Privacy and authorize the release of information necessary to file a claim with my insurance company and assign the benefits payable to the doctor. I have reviewed the Financial Policy and understand that I am financially responsible for any balance not covered by my insurance carrier. Copies of the Notice of Privacy and the Financial Policy are available upon request and they are available on the Premiere Pediatrics Website. I understand both biological parents have access to full disclosure (even if not the custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. If those court orders exist, I must present current copies for my child's file.

A copy of this signature is as valid as the original. Signature _____

Date _____