Patient ID: **Patient Registration**

PLEASE PRINT

Patient Last Name:
Patient First Name:
Patient Middle Initial:
Sex: Date of Birth:
Patient Social Security No.:
Address:

Patient Home Phone
Patient Referred by:_____

Patient Primary Doctor:_____
Patient's Parent Marital Status:

GUARANTOR / PARENT 1 Information (person responsible for payment or policy holder)

Guarantor Name:
Guarantor Address:

Guarantor Home Phone:
Guarantor Mobile Phone:
Guarantor Email Address:
Guarantor Employer:
Guarantor Work Phone:

PARENT 2 Information

PARENT 2 Name:
PARENT 2 Phone number(s):

Primary Insurance Information

Insurance Plan Name:
Insurance Phone Number:

Address to Send Claims:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:
Issue Date:
Exp Date:
Copay Amount:_____
Co-insurance Percent:_____
Sex: **M** or **F**

Policy Holder

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Social Sec Number:
Policy Holder Date of Birth **(REQUIRED)**:
Employer:

Secondary Insurance Information

Insurance Plan Name:
Insurance Phone Number:

Address to Send Claims:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:
Issue Date:
Exp Date:
Copay Amount:_____
Co-insurance Percent:_____
Sex: **M** or **F**

Policy Holder

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Social Sec Number:
Date of Birth:
Employer:

Your patient information may be used to contact you by telephone/mail for the purpose of treatment, payment or heal care operations. If you have any restrictions for communication with you please let us know on this line.

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of the person named and authorize information given to the insurance companies. I agree to pay all charges and interest shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing with the practice. There will be a $25.00 charge if you are a **No Show** for your scheduled appointment.

It is agreed that payment will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and that all proceeds of the insurance for services rendered in the practice are assigned to ASSOCIATED PEDIATRIC PARTNERS SC but without the clinic's assuming sole responsibility for the collection thereof.

Signature: _____ Date: _____

Relationship if other than patient:_____