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**_____

SUBMIT