KIDS CARE, PC

PATIENT REGISTRATION

(PLEASE FILL OUT COMPLETELY - ANY INFORMATION NOT INCLUDED MAY CAUSE A DELAY WITH YOUR INSURANCE. IF YOU HAVE ANY QUESTIONS, FEEL FREE TO ASK US FOR HELP.)

CHILD'S NAME

LAST NAME ______________________ FIRST NAME ______________________ MI ______

ADDRESS ____

CITY ______________________ STATE ______________ ZIP ______________

DATE OF BIRTH ______________ SEX ______________ SS# ______________________

RESPONSIBLE PARTY

LAST NAME ______________________ FIRST NAME ______________________ MI ______

ADDRESS ____

CITY ______________________ STATE ______________ ZIP ______________

RELATIONSHIP TO PATIENT: MOTHER/FATHER/OTHER (PLEASE DESCRIBE IF OTHER) ______________

HOME PHONE ______________________ WORK PHONE ______________________

INSURANCE INFORMATION

MOTHER'S NAME WHO IS LEGAL GUARDIAN ______________________ DATE OF BIRTH ______________

ADDRESS IF DIFFERENT THAN ABOVE ____

SOCIAL SECURITY NUMBER ______________________ MARITAL STATUS ______________

EMPLOYER ______________________ EMPLOYER ADDRESS ______________________

EMPLOYER CITY/STATE/ZIP ______________________________ FULL TIME/PART TIME

EMPLOYER PHONE # ______________________

INSURANCE COMPANY ____

INSURANCE CO. ADDRESS ____

CITY ______________________ STATE ______________ ZIP ______________

TELEPHONE # ______________________ POLICY # ______________________

GROUP # ______________________

FATHER'S NAME WHO IS LEGAL GUARDIAN ______________________________ DATE OF BIRTH ____________

HOME PHONE # ______________________________

ADDRESS IF DIFFERENT THAN ABOVE ____

SOCIAL SECURITY NUMBER ________________________________ MARITAL STATUS ____________________

EMPLOYER _____________________________ EMPLOYER ADDRESS __________________________________

EMPLOYER CITY/STATE/ZIP ____ FULL TIME/PART TIME

EMPLOYER PHONE #_________________________

INSURANCE COMPANY ____

INSURANCE CO. ADDRESS ____

CITY____ STATE ______________________ ZIP _________________

TELEPHONE # _______________________________ POLICY # ____

GROUP # ___________________________________

I authorize the health care staff to perform the necessary services and authorize the person's named below to accompany my child, the above named patient.

Name: _______________________________________ **Relationship:** ________________ **Phone:** _______________

Name: _______________________________________ **Relationship:** ________________ **Phone:** _______________

Name: _______________________________________ **Relationship:** ________________ **Phone:** _______________

As parent of the above named patient, it is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary services that my child may need.

Signature: ____ **Date** _____________________________________

AUTHORIZATION TO RELEASE INFORMATION - ASSIGNMENT OF INSURANCE BENEFITS

I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS, INCLUDING BY ELECTRONIC MEANS IF AVAILABLE AND REQUEST BENEFITS TO BE PAID DIRECTLY TO DR. BOUSO.

____ _____________________________

SIGNATURE **DATE**

____ _____________________________

SIGNATURE **DATE**