Patient Registration Sheet

Patient Information:

Date of Birth _____ / _____ / _____ Age: _______ Race: _______ Sex: M F Chart # ____________

Last Name: ______________________ First Name: ______________________ Middle Initial: ________

Street Address ____________________________City______________State_____Zip__________

Mailing Address (if different from above) ____

Main Contact Phone # ____________________ Second Contact Phone #______________________

E-mail Address for PROVIDER PORTAL ACCESS ____

Emergency Contact ____________________ Relationship ______________ Phone # ____________

Child Lives With _____________ Sibling's names ____

Do you have any religious beliefs that would affect you child's care plan or treatment? YES NO (If yes, please explain: ____

Parent or Guardian Information

Mother's Last Name ____________________ First: ______________________ DOB ____ /____ /____

Address (if different from patient) ____

Employer ____ Work # ________________________

Father's Last Name ____________________ First: ______________________ DOB ____ /____ /____

Address (if different from patient) ____

Employer ____ Work # ________________________

Insurance Information: (copy of current insurance required)

Primary Insurance ________________________ Policy # ______________________ Copay $ _______

Name of Policyholder ____________________________ Relationship to Patient ________________

Secondary Insurance ______________________ Policy # ______________________ Copay $ _______

Name of Policyholder ____________________________ Relationship to Patient ________________

*****Person Responsible for Payment** ____

*** Payments and copays are to be paid at time of service regardless of policy holder. We require a current copy of your insurance card at each visit. If insurance information is not provided at time of service, payment will be required in full unless prior financial arrangements have been made with our insurance department.

Authorization of Treatment and Assignment of Benefits

I authorize Shore Fun Pediatrics to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms and for continuity of care. I authorize payment directly to Shore Fun Pediatrics for all medical benefits otherwise payable to me under the terms of insurance. A photocopy of this authorization shall be considered as effective and valid as the original. If insurance is unable to be filed, I understand that I am to pay at the time services are rendered. **I understand that 60 days from the date of service if insurance has not paid I will be responsible for the balance.** I certify that the information I have reported with regard to the insurance information and person responsible is correct.

I understand that if my child's provider or employee's under the direction of my child's provider is directly exposed to my child's body fluids in any manner which may, according to the current guidelines for the Center of Disease Control, transmit the HIV, Hepatitis B or C viruses, that I am deemed by law to have consented to the release of the test results to the person who is exposed to my child's body fluids.

Parent/Guardian's Signature ____

Relationship to Child ____________________ **Today's Date** ____________________