Children's Physicians Patient Registration

Patient and Sibling Information

Last	First	Middle	DOB	SSN	Gender Identity
					M / F / Other
					M / F / Other
					M / F / Other

If patient is 16 years and older, their phone number is ______________________________

Parent's Information

Mother's Information	Father's Information
Last First Middle DOB	Last First Middle DOB
SSN:____________________	SSN:____________________
Email:____________________	Email:____________________
Street Address:____________________	Street Address:____________________
City/State/Zip:____________________	City/State/Zip:____________________
Cell Phone:____________________	Cell Phone:____________________
Name of Employer:____________________	Name of Employer:____________________
Work Phone:____________________	Work Phone:____________________

Parents' Marital Status: □ Married □ Single □ Divorced/Separated

Insurance Information

Insurance Name____________________ Policyholder:____________________

Policy Number:____________________ Group/Plan Name:____________________

Guarantor's Information (to whom statements are sent, if different from above)

Name____________________ Relationship:____________________

Street Address:____

City/State/Zip:____________________ Phone:____________________

Emergency Contact Information

Name (other than parent):____________________ Relationship:____________________

Street Address:____

City/State/Zip:____________________ Phone:____________________

How did you hear of us or who referred you? (Mark all that applies)

□ Friend/Relative: (name)____________________ □ Doctor/Hospital: (name)____________________

□ Insurance □ Internet □ Social Media □ Drive By □ Previous Patient

Race □ White □ Black/African □ Native American or Alaska Native
□ Asian □ Native Hawaiian or Other Pacific Islanders

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino

Language □ English □ Spanish □ Creole □ Chinese
□ Japanese □ Vietnamese □ Filipino □ Other:____________

Pharmacy:____________________ Phone #____________________

PERSONS AUTHORIZED TO BRING CHILD IN FOR APPOINTMENTS – OTHER THAN PARENTS – (must be 18 years of older)

Name:____________________Relationship to Patient:____________DOB:________Phone:________

Name:____________________Relationship to Patient:____________DOB:________Phone:________

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Children's Physicians, all insurance benefits otherwise payable to me for services rendered. I authorize Children's Physicians to release any information required to secure payment of benefits from my insurance. I authorize the use of this signature on all insurance submissions, and to download any available medication history.

CONSENT FOR TREATMENT

On behalf of this(ese) child(ren), I voluntarily consent to the rendering of medical care by Children's Physicians. I understand that the child(ren) is under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instruction of such physician(s).

STATEMENT OF FINANCIAL LIABILITY

I guarantee payment of any and all bills rendered for said child(ren) which are not covered or allowable by insurance. This office will file the bill with my insurance company, providing I supply the proper insurance information to this office.

I understand if I have an unpaid balance to Children's Physicians and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Children's Physicians or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Children's Physicians and the designated external collection agency are authorized to contact me by telephone at the telephone number(s) I am providing, including wireless telephone.

Signature of Responsible Party: ____ Date: ____________________

Print Name: ____