

Date _____

PATIENT REGISTRATION

Patient Name _____ DOB _____ SEX _____

Address _____

City,State,Zip _____

Who does child live with _____

Parent's marital status _____

Sibling's Names _____

Person (other than parent) for emergency contact

Name _____ Phone _____

Relationship to patient _____

Who is to receive any bills not covered by insurance _____

Primary care physician _____

Mother's Name _____ DOB _____

Address _____

City,State,Zip _____

Contact phone number _____

Employer _____ Work Phone _____

Occupation _____

Email address _____

Preferred way to be contacted _____

Father's Name _____ DOB _____

Address _____

City,State,Zip _____

Contact phone number _____

Employer _____ Work Phone _____

Occupation _____

Email address _____

Preferred way to be contacted _____

Primary Insurance _____

Policy Holder/relationship to patient _____

ID# _____ Group # _____

Secondary Insurance _____

Policy Holder/relationship to patient _____

ID# _____ Group# _____

Please sign next page

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private and any other health plan to Fenton Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance and for payment of this account. This will apply to charges incurred by Fenton Pediatrics in any hospital or at the practice location. If the account is sent to a collection agency, I will be responsible for any agency or collection fee.

Consent to Treatment: I hereby authorize Fenton Pediatrics or whomever they may designate, to administer treatment to my child.

Acknowledgement of Receipt of notice of Privacy Practices: I hereby acknowledge that I have been provided the Fenton Pediatrics' Notice of Privacy Practices, which provides a description of how the practice might use and disclose personal health information for the purposes of treatment, payment and healthcare operations.

As the parent of _____, I give Fenton Pediatrics, permission to treat and /or immunize my child in the event that I am unable to accompany him/her to the office. I understand that in all situations, the doctors prefer to have a parent present to obtain a medical history and to give permission for treatment or vaccinations. By sending my child with a caregiver or by sending my adolescent child alone, I am giving consent to any medical procedure the physician deems necessary.

Signature _____

Relationship to Patient _____

Date _____