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_______________________________Social_______________
Employer___________________________________Work Phone________________
Occupation____
Email address____
Preferred way to be contacted____

Father's Name____DOB__________
Address____
City,State,Zip____
Contact phone number_______________________________Social_______________
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____