

Pediatric Partners LLC
PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____ Male/Female (please circle)

Siblings: (that are to be billed w/ patient)

_____ Date of Birth: _____ Male/Female
_____ Date of Birth: _____ Male/Female
_____ Date of Birth: _____ Male/Female
_____ Date of Birth: _____ Male/Female
_____ Date of Birth: _____ Male/Female

Parent or Guardian: (Person responsible for bill)

Name: _____ Married/Single/Divorced/Widowed (please circle)
Address: _____ Home Phone #: _____ Cell Phone #: _____
City: _____ State: _____ Zip: _____
Employer Phone #: _____

Other parent/Guardian:

Name: _____ Married/Single/Divorced/Widowed (please circle)
Address: _____ Home Phone #: _____ Cell Phone #: _____
City: _____ State: _____ Zip: _____
Employer Phone #: _____

IN CASE OF EMERGENCY CONTACT (person living outside your household):

Name: _____ Phone #: _____ Relationship: _____

PRIMARY INSURANCE:

Name of Subscriber: _____
Subscriber Date of Birth: _____ Subscriber SS#: _____ Relationship to patient: _____
Employer: _____
Insurance Company Name: _____
Does the above insurance apply to all siblings? YES/NO (please circle)

SECONDARY INSURANCE: (If applicable)

Name of Subscriber: _____
Subscriber Date of Birth: _____ Subscriber SS#: _____ Relationship to patient: _____
Employer: _____
Insurance Company Name: _____
Does the above insurance apply to all siblings? YES/NO (please circle)

PHARMACY: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Pediatric Partners LLC. I understand that I am financially responsible for any balance unpaid. I also authorize Pediatric Partners LLC to release any information required to process my claims.

Parent Signature: _____ Date: _____