

South River Pediatrics Patient Registration Form

Date ____ / ____ / ____

Patient Information

Patient's Name _____		Sex (M/F) _____
Date of Birth ____ / ____ / ____	_____	Social Security # _____ - _____ - _____
Home Address _____	_____	_____
City _____	State _____	Zip Code _____
Home Phone (____) _____ - _____	Work Phone (____) _____ - _____	Cell Phone (____) _____ - _____
E-mail Address _____		
Emergency Contact: _____	Phone # (____) _____ - _____	
Siblings Name(s) _____		

Parent Information

Mother's Name _____		_____
Date of Birth ____ / ____ / ____	_____	Social Security # _____ - _____ - _____
Home Address _____	City _____	State _____
Zip Code _____	Home Phone (____) _____ - _____	Work Phone (____) _____ - _____
Cell Phone (____) _____ - _____	Occupation _____	
E-mail Address _____		

Father's Name _____		_____
Date of Birth ____ / ____ / ____	_____	Social Security # _____ - _____ - _____
Home Address _____	City _____	State _____
Zip Code _____	Home Phone (____) _____ - _____	Work Phone (____) _____ - _____
Cell Phone (____) _____ - _____	Occupation _____	
E-mail Address _____		

Primary Health Insurance Information

Name of Insurance Plan _____	Date Insurance Began _____
Name of Person Who Carries Insurance _____	
Relationship _____	Employer _____
Insurance Identification Number/Policy Number _____	
Group Number _____	Co-Pay Amount \$ _____
Insurance Company Address _____	

Acknowledgement of Financial Responsibility

<p>I, _____, acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing health coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to South River Pediatrics. I understand that I am responsible for meeting my insurance deductibles and coinsurance and any noncovered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to South River Pediatrics.</p>
