PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last)*_____Date of Birth _____ Male / Female

Name (*First, M.I., Last)*_____Date of Birth _____ Male / Female

Name (*First, M.I., Last)*_____Date of Birth _____ Male / Female

Name (*First, M.I., Last)*_____Date of Birth _____ Male / Female

Patient Address _____**City**_____ **State:**_____**Zip:**_____

Referred by: _____

Appointment Reminders by: ___ Phone call ___ Text ___ Email

Parent/Legal Guardian Information

Name _____ DOB:_____SSI: _____

Relationship to Patient _____ Mobile #: _____ Carrier: _____

Email: _____ Marital Status: S M W D

Employer _____

Name _____ DOB:_____SSI: _____

Relationship to Patient _____ Mobile #: _____ Carrier: _____

Email: _____ Marital Status: S M W D

Employer _____

Person authorized to bring your child/children other than parents/legal guardian

Name _____Phone: _____Relationship to Patient _____

Name _____Phone: _____Relationship to Patient _____

The above named shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures for the above named child/children, which may be required during my absence. I agree to pay for all services provided to my child/children in my absence.

This authorization is effective until _____, unless earlier revoked by me. Parent Signature: _____

Authorization to Release Information, Assignment of Benefits and Financial Agreement

I authorize the release of any medical information necessary to process our claims. I permit a copy of this authorization to be used in the place of the original.

I hereby authorize Advanced Kids Care, P.A. to apply for benefits on my behalf for covered services rendered by the provider. I request the payment from my insurance company to be made directly to Advanced Kids Care, P.A.

I acknowledge that payment is due at the time of treatment, unless other arrangements are made prior. I agree that the parents/legal guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by my insurance. I have been provided with a copy of the Privacy Notice and have had the opportunity to object to the disclosures of my health information.

Parent Signature _____ Date _____

*******PLEASE PROVIDE THE FRONT OFFICE WITH A CURRENT COPY OF YOUR HEALTH INSURANCE.**