PEDIATRIC PATIENT REGISTRATION FORM

Patient's DOB:_____ Patient's Age: _____
Patient's Last Name:_____ First & Middle Name:_____
Patient's SSN:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Circle one: Male / Female

Please provide names of siblings that are also patients: _____
_____

Responsible Party Information
Father's Name:_____ SSN:_____ DOB:_____
Employer's Name:_____ Occupation:_____
Work Phone:_____ Cell Phone:_____
Email: _____

Mother's Name:_____ SSN:_____ DOB:_____
Employer's Name:_____ Occupation:_____
Work Phone:_____ Cell Phone:_____
Email: _____

*****Please circle preferred contact number above.**

Insurance Information
Name of Insurance:_____ Copay:_____
ID #:_____ Group #:_____
Policy Holder's Name:_____ Policy Holder's DOB:_____
Policy Holder's SSN:_____ Effective Date:_____
Insurance Claims Address & Phone #:_____

I have completed this form fully and certify that I am the patient or legal guardian authorized to furnish all the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered. I also understand that Arlington Physicians, PA only files for HMO and PPO insurance plans. I also understand that there is a charge of $25 - $100 for not showing up to an appointment, which I am responsible for those fees.

I hereby assign to the above named doctor all benefits, rights, and proceeds for services rendered under any insurance policies, any reimbursement, or prepaid healthcare plans. I hereby authorize the release of pertinent information to insurance carriers and **agree to pay all charges incurred**.

Children of Divorced Parents: Responsibility for payment of treatment of minor children whose parents are divorced, rests with the parent who brings the child(ren) into the office. Any court ordered responsibility judgment must be determined between the individuals, without the inclusion of Arlington Physicians, P.A.

Signature:_____ Date:_____

Referred By:_____

For office use only: **Physician:_____**
Date Verified:_____ Initials:_____ Date Verified:_____ Initials:_____
Date Verified:_____ Initials:_____ Date Verified:_____ Initials:_____
Date Verified:_____ Initials:_____ Date Verified:_____ Initials:_____
Date Verified:_____ Initials:_____ Date Verified:_____ Initials:_____