

PREMIER PRIMARY CARE PHYSICIANS

PEDIATRIC PATIENT REGISTRATION

Under 18 yrs old - Please print and fill in All Areas)

Patient Information

Child's (Legal) Name: First Name - MI - Last Name		Nick Name	Birth Date	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Soc. Sec#
Home Address			City	State	Zip
Home Phone Number (Child)	Cell Phone Number (Child)	May we leave a confidential message at this number? Y / N			
Ethnicity	Preferred Language	Preferred Contact Phone Number:			

Mother (circle one) Birth / Stepmother / Adoptive mother / Foster *Any custody concerns?* Y / N *Legal guardian?* Y / N

Mother's Full Name (First M. Last)		Social Security #	Date of Birth		
Home Address		City	State	Zip	
Mother's Employer Name & Address			Home Phone Number/Cell Phone Number		
			Business Phone Number		
Preferred telephone contact is: (circle one) Home / Cell / Business			May we leave a confidential message at this number? Y / N		

Father (circle one) Birth / Stepfather / Adoptive father / Foster *Any custody concerns?* Y / N *Legal guardian?* Y / N

Father's Full Name (First M. Last)		Social Security #	Date of Birth		
Home Address		City	State	Zip	
Father's Employer Name & Address			Home Phone Number/Cell Phone Number		
			Business Phone Number		
Preferred telephone contact is: (circle one) Home / Cell / Business			May we leave a confidential message at this number? Y / N		

Emergency Contact (Friend or Relative)

Name	Relationship	Phone Number
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Primary Insurance Information	Secondary Insurance Information
Insurance Name: _____	Insurance Name: _____
Policy/ID #: _____	Policy/ID #: _____
Group/Plan #: _____	Group/Plan #: _____
Insurance Effective Date: _____	Insurance Effective Date: _____
Policy Holder Name: _____	Policy Holder Name: _____
Employer: _____	Employer: _____
Policy Holder SSN/DOB: _____	Policy Holder SSN/DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____

How did you hear about us? Internet Insurance Company Personal Reference If so who? _____

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Premier Primary Care Physicians for any services furnished me by the physicians. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Signature of Patient/Guardian/Guarantor	Date
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Acknowledgement of Privacy Practices: I have received notice of the Privacy Practices of Premier Primary Care Physicians and I have been provided an

Signature of Patient/Guardian/Guarantor	Date
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