

Patient Registration Form
(Please Complete All Blanks)

Last Name: _____ **Date:** _____

Names of Children

_____	Birthdate: _____	Sex: M F
_____	Birthdate: _____	Sex: M F
_____	Birthdate: _____	Sex: M F
_____	Birthdate: _____	Sex: M F

Parent Responsible for Payment

Name: _____ Relationship: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Father _____ Employer: _____
Social Security #: _____ Birthdate: _____ Work Phone: _____

Mother _____ Employer: _____
Social Security #: _____ Birthdate: _____ Work Phone: _____

Medical Insurance Information

None

Name of Company: _____ Name of Insured: _____
ID#: _____ Group #: _____
Name of Company: _____ Name of Insured: _____
ID#: _____ Group #: _____

- I authorize payment of medical benefits to my physician for professional services rendered.
 I authorize the release of any medical information to my insurance company.

Signature: _____

Referred by: _____

Person to contact in case of an emergency other than parent:

Name: _____ Phone: _____

If I am unavailable, I request The Pediatric Center, or any physician they may delegate, to give any and all medical or surgical care to the above named children. This includes my permission for the children to be admitted to a hospital and for the performance of surgery and anesthesia as deemed advisable by the above named physicians or their delegates.

Signed: _____