

THE PEDIATRIC CENTER

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PATIENT REGISTRATION (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 _____ Home Phone _____

City _____ State _____ Zip _____

Family Email address _____

(this will be kept secure and will not be shared with any other offices/companies)

Father _____ Employer _____

Birthdate _____ Work Phone _____ Cell Phone _____

Mother _____ Employer _____

Birthdate _____ Work Phone _____ Cell Phone _____

Medical Insurance Information None

Name of Company _____ Policy Holder _____

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 _____