Patient Registration

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Pediatric Offices at Willow Bend

IS THIS YOUR FIRST VISIT AT THIS OFFICE? ☐ Yes ☐ No **TODAY'S DATE:** _____
HOW DID YOU HEAR ABOUT US? Friend/Family Insurance Internet Hospital Other

PATIENT INFORMATION

Patient Name : _____ Patient Date of Birth_____ Sex: M F
Home Address:_____
City: _____ State: _____ Zip Code: _____ Home Telephone: _____
Next of Kin (not Living at address listed above): _____ Relationship: _____
Next of Kin Address: _____
Siblings Name on same insurance: _____ **DOB** (mm/dd/yy) Sex: M F _____
_____ Sex M F _____
_____ Sex: M F _____

PARENT INFORMATION

Marital Status of Parents: Married Divorced or Divorced Pending Single (Never Married)
Mother's Name: _____ Date of Birth: _____ SS#: _____
E-Mail Address: _____ Check here if you already receive our emails
Home Address (if different from child): _____
City: _____ State: _____ Zip Code: _____ Primary Phone: _____
Employer: _____ Work Phone: _____ Alt. Phone: _____
Employer: _____ Work Phone: _____ Alt. Phone: _____
Father's Name: _____ Date of Birth: _____ SS#: _____
E-Mail Address: _____ Check here if you already receive our emails
Home Address(if different from child): _____
City: _____ State: _____ Zip Code: _____ Primary Phone: _____
Employer: _____Work Phone: _____ Alt. Phone: _____

INSURANCE

Primary Insurance: _____ Effective Date: _____
Full Name of Policy Holder: _____ Date of Birth: _____ SS#: _____
Employer: _____ Policy Type: HMO PPO PPC Other
ID Number: _____ Group Number: _____
Preferred Pharmacy Name: _____ Location? Phone: _____
Previous Physician: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that payment of all medical care is due at the time of service. The parent and /or legal guardianwho signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of medical status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Pediatric Offices At Willow Bend to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pediatric Offices At Willow Bend.

A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____ _____
***Billing Guarantor Name** (print)* **Signature** **Date**

****Return this form to a staff member before leaving the office. Thank you.****