PATIENT REGISTRATION FORM

Date: _____

Patient's Name: _____ _____
Last First Middle Date of Birth

Address: _____
Street Apt # City State Zip

Home Phone #: _____ Sex: ____

Other Children: Name: _____ Sex: ____ DOB: _____

_____ Sex: ____ DOB: _____

_____ Sex: ____ DOB: _____

PARENT/GUARDIAN INFORMATION

Parent's Name: _____ Parent's Name: _____

DOB: _____ DOB: _____

Cell Phone: _____ Cell Phone: _____

Social Security #: _____ Social Security #: _____

Driver's License #: _____ Driver's License #: _____

Employer: _____ Employer: _____

E-Mail: _____ E-Mail: _____

Person Responsible for Payment: _____

Billing Address: _____
Street Apt # City State Zip

Emergency Contact Other Than Parents: _____

Relationship to Patient: _____ Phone #: _____

Primary Doctor (Circle One) Dr. Schorlemer Dr. Hieber Dr. Hanig
Dr. Fernandez Dr. Burns Dr. Shinn

INSURANCE INFORMATION

Insurance Company: _____ Policy Holder Name: _____

Policy or Subscriber #: _____ Group: _____

I authorize my insurance company to make payments to Clinical Pediatric Associates for my insurance claims. I also appoint Clinical Pediatric Associates to act as my authorized representative when requesting an appeal from my insurance company regarding its denial of service or payment.

Signature: _____ **Date:** _____