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**Pediatric  
Physicians,  
PC**

**Child  
Registration**

PPPC Account # \_\_\_\_\_

**Your kindness in furnishing the following information will be appreciated. The information will be used in strict confidence to prepare your child's chart.**

Child's full name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Name your child is called: \_\_\_\_\_

Does child live with both parents? \_\_\_\_\_ If not, who is the legal guardian? \_\_\_\_\_

**Father's Information:**

Father's full name: \_\_\_\_\_ DOB \_\_\_\_\_ SS # \_\_\_\_\_

Father's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Father's home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

**Mother's Information:**

Mother's full name: \_\_\_\_\_ DOB \_\_\_\_\_ SS # \_\_\_\_\_

Mother's Address, if different from father's: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mother's home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

**Emergency Information:**

Whom shall we call other than parents? \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Insurance Information: Who is the policy holder for the insurance? \_\_\_\_\_

Who is responsible for copays? \_\_\_\_\_ Who should receive any bills? \_\_\_\_\_

**If you have other children, please list names and birth dates below:**

\_\_\_\_\_  
\_\_\_\_\_

- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
- IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.
- If this account is assigned for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
- To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.
- I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to **Pediatric Physicians, PC**.
- This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
- I have been given the opportunity to review the Notice of Privacy Practices for **Pediatric Physicians, PC**.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_