

# New Patient Registration

## Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Gender \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please list any other siblings that go to this practice: \_\_\_\_\_

## Parent Information:

### Mother:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Employer Name: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

### Father:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Employer Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Who may we thank for referring you:

OB \_\_\_\_\_ Advertisement \_\_\_\_\_

Other \_\_\_\_\_ Insurance company \_\_\_\_\_

## Emergency Contact:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name(s) of others who may seek medical care in parent's absence: \_\_\_\_\_

I hereby authorize East Lake Pediatrics to furnish all information to insurance carriers concerning my illness, and/or treatments, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by insurance; this includes any course of treatment that is not a covered benefit. I understand that I am responsible for notifying East Lake Pediatrics of any changes in my insurance coverage. If I am delinquent in updating this information and charges are denied, I understand that I will be held responsible for these charges. I agree and understand that if my account is turned over to a collection agency, I am responsible for any cost incurred in collection of said balances, which may include being charged up to 1.5% interest rate per month on any unpaid balance.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_