PEDIATRIC PATIENT REGISTRATION FORM

Patient's DOB:____________________ Patient's Age: _________
Patient's Last Name:______________________ First & Middle Name:_________________________
Patient's SSN:_________________________
Address:____
City:_________________________________ State:________ Zip Code:_______________
Home Phone:_________________________ Circle one: Male / Female

Please provide names of siblings that are also patients: ____
____
____

Responsible Party Information
Father's Name:___________________________________ SSN:_______________ DOB:__________
Employer's Name:_____ ___________________________ Occupation:_________________________
Work Phone:_________________________ Cell Phone:_________________________

Mother's Name:____ ______________________________ SSN:_______________ DOB:__________
Employer's Name:_________ _______________________ Occupation:_________________________
Work Phone:_________________________ Cell Phone:_________________________

*****Please circle preferred contact number above.**

Insurance Information
Name of Insurance:_________________________ Copay:__________
ID #:_____________________________ Group #:______________________________
Policy Holder's Name:_________________________ Policy Holder's DOB:_______________
Policy Holder's SSN:_________________________ Effective Date:___________________
Insurance Claims Address & Phone #:____

I have completed this form fully and certify that I am the patient or legal guardian authorized to furnish all the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered. I also understand that Arlington Physicians, PA only files for HMO and PPO insurance plans. I also understand that there is a charge of $25 - $100 for not showing up to an appointment, which I am responsible for those fees.

I hereby assign to the above named doctor all benefits, rights, and proceeds for services rendered under any insurance policies, any reimbursement, or prepaid healthcare plans. I hereby authorize the release of pertinent information to insurance carriers and **agree to pay all charges incurred**.

Signature:____ Date:___________________

For office use only: **Physician:**________________________________
Date Verified:__________ Initials:__________ Date Verified:__________ Initials:__________
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