PATIENT REGISTRATION FORM

PATIENT INFORMATION

Child's Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ / _____ / _____ Age _____ Sex of Patient ☐ Male ☐ Female Social Security # _____-_____-_____

School Name _____ City/State _____

Names of brothers or sisters _____

Name of Child's Legal guardian _____ **Relationship to child** _____

LEGAL GUARDIAN INFORMATION (if other than father or mother)

Name _____ Social Security # _____-_____-_____

Address _____ Date of Birth _____ / _____ / _____

City/State/Zip _____ Home Phone # _____-_____-_____

Employer _____ Portable/Cell # _____-_____-_____

Work Phone # _____-_____-_____ Ext _____

FATHER'S INFORMATION

Name _____ Social Security # _____-_____-_____

Address _____ Date of Birth _____ / _____ / _____

City/State/Zip _____ Home Phone # _____-_____-_____

Employer _____ Portable/Cell # _____-_____-_____

Work Phone # _____-_____-_____ Ext _____

MOTHER'S INFORMATION

Name _____ Mother's Maiden Name _____

Address _____ Social Security # _____-_____-_____

City/State/Zip _____ Date of Birth _____ / _____ / _____

Employer _____ Home Phone # _____-_____-_____

Work Phone # _____-_____-_____ Ext _____ Portable/Cell # _____-_____-_____

INSURANCE INFORMATION

Is patient covered by Medicaid or PeachCare? ☐ Yes ☐ No ☐ Not currently, but has applied for Medicaid or PeachCare.

Primary Insurance Company _____ Effective date _____ / _____ / _____

Seconday Insurance Company _____ Effective date _____ / _____ / _____

EMERGENCY CONTACT [Other than parent or guardian]

Name _____ Phone # _____-_____-_____ Relationship _____

Name _____ Phone # _____-_____-_____ Relationship _____

RELEASE OF AUTHORIZATION / ASSIGNMENT OF BENEFITS [must read, sign and date]

I authorize the release of any medical information necessary to process my insurance claim (s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand I am financially responsible for all charges not covered by Medicaid.

Signature _____ Date: _____ / _____ / _____