PATIENT REGISTRATION FORM

Patient Full Legal Name _____ Date of birth_____

Home Address _____

City: _____State _____ Zip _____

Ethnicity: □ Non-Hispanic □ Hispanic □ Not specified.

Race: □ African or African American. □ Asian or Asian American. □ Caucasian or European American. □ Native American or Native Alaskan. □ Native Hawaiian or other Pacific Islander. □ Other race

PARENT/ GUARDIAN INFO

Name_____ Birth Date _____

Relationship to Child_____

Home Address (if different than above)_____

Phone numbers (H) _____ (Cell) _____

INSURANCE INFO/ RESPONSIBLE PARTY

Insurance company _____Group #_____

Child's ID # _____ Insurance policy holder's name _____

Relationship to child _____

EMERGENCY CONTACT INFO (**not living with patient**)

Name _____ Relationship _____ Ph # _____

I hereby assign the benefits from any insurance or third party to GENTLE PEDIATRICS PLLC for medical services provided to my child. I understand that GENTLE PEDIATRICS PLLC has the right to decline or accept assignment of such benefits. If these benefits are not assigned to GENTLE PEDIATRICS PLLC, I agree to forward to the practice, upon receipt, any insurance or third-party payments I receive for services rendered to me. I authorize the release of any medical information needed to determine the benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Parent/Guardian Signature _____ _____ Date _____