

PATIENT REGISTRATION NEW UPDATED

ACCEPTED BY: _____

PATIENT INFORMATION

| | | | | |
|-------------------|-------|--|----------------------|-----|
| NAME LAST | FIRST | MIDDLE | NICKNAME | |
| SOCIAL SECURITY # | | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | DATE OF BIRTH / / | |
| STREET ADDRESS | | CITY | STATE | ZIP |
| HOME PHONE # [] | | | | |

GENERAL INFORMATION

| | |
|--|----------------------------------|
| Father's full name _____ | Mother's full name _____ |
| Address _____ | Address _____ |
| City _____ State _____ Zip _____ | City _____ State _____ Zip _____ |
| Home phone (_____) _____ | Home phone (_____) _____ |
| Cell phone (_____) _____ | Cell phone (_____) _____ |
| Date of birth _____ | Date of birth _____ |
| Occupation _____ | Occupation _____ |
| Employer _____ | Employer _____ |
| Work phone _____ | Work phone _____ |
| Company address _____ | Company address _____ |
| E-Mail address _____ | E-Mail address _____ |
| Child lives with: <input type="checkbox"/> both parents <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> other _____ | |
| Name(s) and age(s) of brother(s) & sister(s): _____ | |
| Who is responsible for your child's account? _____ | |

PROOF OF INSURANCE IS REQUIRED BY PROVIDING INSURANCE CARD AT EACH TIME OF SERVICE

INSURANCE INFORMATION

| PRIMARY INSURANCE | | SECONDARY INSURANCE | |
|--------------------------|-------------------|--------------------------|-------------------|
| INSURANCE COMPANY NAME | | INSURANCE COMPANY NAME | |
| POLICY HOLDERS NAME | | POLICY HOLDERS NAME | |
| DATE OF BIRTH | SOCIAL SECURITY # | DATE OF BIRTH | SOCIAL SECURITY # |
| RELATIONSHIP TO PATIENT: | | RELATIONSHIP TO PATIENT: | |

EMERGENCY CONTACT INFORMATION

| | | |
|--------------|-------------------------|--------------|
| NAME | RELATIONSHIP TO PATIENT | |
| HOME PHONE # | WORK PHONE # | CELL PHONE # |

I understand that I am financially responsible for all charges whether or not they are paid by my insurance or employer. I authorize said assignee to release all information necessary to secure the payment. I assign surgical benefits, major medical or Medicare to Kids Health Partners, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is as valid as an original.

PATIENT OR LEGAL GUARDIAN SIGNATURE _____ DATE: ____/____/____