

PATIENT REGISTRATION

NEW

UPDATED

TODAY'S DATE _____

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

PARENT/GUARDIAN #1- FULL NAME			PARENT/GUARDIAN #2- 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 #		
EMPLOYER ADDRESS			EMPLOYER ADDRESS		
E-MAIL ADDRESS			E-MAIL ADDRESS		
CHILD LIVES WITH:			WHO IS RESPONSIBLE FOR YOUR CHILD'S ACCOUNT?		
NAME(S) AND AGE(S) OF BROTHERS & SISTERS					

INSURANCE INFORMATION

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

PRIMARY INSURANCE COMPANY NAME			SECONDARY INSURANCE COMPANY NAME		
POLICY HOLDER'S NAME			POLICY HOLDER'S 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 ____/____/____