By Your Side… From Crawling to Flying

PATIENT REGISTRATION

DATE: ______________________

PATIENT'S INFORMATION			
Name:		Gender:	DOB:
Address:	City:	St:	Zip:
Home #:	SSN#:		
Name/Address Pharmacy:	Phone:		
MOTHER'S INFORMATION			
Mom's Name:		DOB:	SS#
Address:	City:	St:	Zip:
Employer:		Occupation:	
Work Number:		Home Number:	
Email:		Phone:	
FATHER'S INFORMATION			
Dad's Name:		DOB:	SS#
Address:	City:	St:	Zip:
Employer:		Occupation:	
Work Number:		Home Number:	
Email:		Phone:	
GUARDIAN'S INFORMATION			
Name:		DOB:	SS#
Address:	City:	St:	Zip:
Employer:		Occupation:	
Work Number:		Home Number:	
Email:		Phone:	
EMERGENCY CONTACT (OTHER THAN PARENTS)			
Name:	Address/Phone:		
CLOSEST RELATIVE (NOT LIVING WITH FAMILY)			
Name:	Address/Phone:		
INSURANCE/BILLING INFORMATION			
Responsible person: ☐ Father ☐ Mother ☐ Other:			
Billing Address:			Phone:
PRIMARY INSURANCE			
Name: |DOB:		Address:	
Pol#	Group #:	Benefit Code:	Effect. Date:
Policy Holder Name:			
SECONDARY INSURANCE			
Name: |DOB:		Address:	
Pol#	Group #:	Benefit Code:	Effect. Date:
Policy Holder Name:			
Medicaid #:		Medicare:	
ADDITIONAL INSURANCE INFORMATION:			

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE PAYMENT OF SURGICAL/MEDICAL BENEFITS TO VIVA PEDIATRICS, P.A. FOR SERVICES RENDERED BY A MEMBER OF THE GROUP.
AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE VIVA PEDIATRICS, P.A. TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS. A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL.
I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY SERVICES RENDERED. I HAVE READ ALL THE ABOVE INFORMATION AND HAVE COMPLETED IT. I CERTIFY THAT ALL THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN HEALTH STATUS OR THE ABOVE INFORMATION.

_________________________________ _________________________________

Print Name of Guarantor: Signature of Guarantor:

_________________________________ _________________________________

Print Patient Name: DOB: Relationship to Patient:

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Date: