

# PATIENT REGISTRATION FORM

Please enter ALL children on this sheet so we may connect your FAMILY in our system

LAST NAME, FIRST      M/I      DOB      M/F      SS#      LIVES WITH      CUSTODY

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

MOM'S NAME \_\_\_\_\_ email \_\_\_\_\_

Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Employer \_\_\_\_\_ Mom's DOB \_\_\_\_\_ SS# \_\_\_\_\_

Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Stepdad's name (if applicable) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

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DAD'S NAME \_\_\_\_\_ email \_\_\_\_\_

Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Employer \_\_\_\_\_ Dad's DOB \_\_\_\_\_ SS# \_\_\_\_\_

Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Stepmom's name (if applicable) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

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*How did you hear about us?    Family    Friend    Newspaper    Hospital    Billboard    Phonebook    Internet*

*How would you prefer to be contacted -home phone#, cell phone#, email, mail or text (when able) regarding:*

*Appointment reminders* \_\_\_\_\_

*Lab results* \_\_\_\_\_

*Consult appointments* \_\_\_\_\_

*Billing issues/statements* \_\_\_\_\_

*What email address do you want to have access to our PATIENT PORTAL regarding this patient?*

**(ONLY ONE EMAIL ADDRESS CAN HAVE ACCESS TO THIS PORTION OF YOUR CHILD'S CARE)**

\_\_\_\_\_

Who is **legal guardian** of the child/children? \_\_\_\_\_  
(If not both parents, please provide a copy of legal documentation stating custody)

**Whose** insurance policy is responsible for the child/children? \_\_\_\_\_

Who may bring child/children for treatment other than parents? How are they related? (Please provide phone numbers)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For safety, a note from the guardian and ID of the person bringing your child will be required for someone not listed above.

**Signature** \_\_\_\_\_ **Date Completed** \_\_\_\_\_

### INSURANCE INFORMATION

**PRIMARY INSURANCE**—Company Name \_\_\_\_\_

Ins. Company Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**SECONDARY INSURANCE**----Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH ALL NECESSARY INFORMATION TO BILL YOUR INSURANCE COMPANY.**

***THE PARENT WHO REQUESTS CARE IS RESPONSIBLE FOR ALL CHARGES THAT RESULT***

**ASSIGNMENT AND RELEASE OF INFORMATION:** (please initial at each line)

\_\_\_\_\_  
I, the undersigned certify that I have insurance coverage as listed above and assign to Wee Care Pediatrics Group PLLC and its physicians all Medicaid and Insurance benefits for services rendered.

\_\_\_\_\_  
I understand that I am responsible for the balance of my child's bill if payment has not been received within 90 days of services rendered.

\_\_\_\_\_  
Authorization to Release Medical Information: I hereby authorize the release of medical records developed in, or for the care of my child to establish a health insurance claim.

\_\_\_\_\_  
Treatment Authorization: I hereby authorize medical treatment as physician deems necessary.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_