CHILD REGISTRATION/UPDATE (13 years old or younger)

PLEASE FILL OUT THIS FORM COMPLETELY. THANK YOU.

CHILD INFORMATION:

Name:_____ **Birthdate:**_____ **Sex M F**

Address:_____ **Social Security #:**_____

City/State/Zip:_____/_____/_____

Home #:_____

Race: (Please circle one) 1. Non-Hispanic or Latino 2. Hispanic or Latino

Ethnicity: (Please circle one) 1.Caucasian 2. African American 3. Asian 4. American Indian/Alsaka Native

5. Native Hawaiian or Other 6. Pacific Islander 7. More than one

Who referred you to our office? (Please circle one) **Patient Insurance Online Other** _____

List Allergies to Medications:_____

PARENT OR LEGAL GUARDIAN INFORMATION:

Name_____ **Birthdate:**_____ **Sex M F**

Address: Same as above? (Please circle one) **Yes No**

If no:
Address:_____ **Social Security #:**_____

City/State/Zip:_____/_____/_____

Home #:_____ **Cell #:**_____

Email Address:_____

EMERGENCY CONTACT INFORMATION: (Please provide two contacts)

Who to notify in case of emergency: **Name:**_____

Phone #:_____

Who to notify if above doesn't answer: **Name:**_____

Phone:_____

*****OVER*****

INSURANCE SUBSCRIBER INFORMATION: (Policy Holder's Information)

Please Circle one: Self Father Mother Husband Wife Subscriber Date of Birth:_____

Employer Name:_____ ***(Fill in if the Insurance is through Employment)***

Work Phone #:_____

Address:_____

City/State/Zip:_____/_____/_____

Social Security #:_____

Occupation:_____

******INSURANCE- PLEASE BRING ALL INSURANCE CARDS TO THE RECEPTIONIST EVERY VISIT******

THE POLICY OF OUR OFFICE IS: THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES OF SERVICES RENDERED

ALL PATIENTS

I hereby authorize release of information necessary to file a claim payable with my insurance company and assign benefits otherwise payable to me, to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier.

_____ _____/_____/_____

Signature of Legal Guardian Date

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Family Doctor for any services furnished to me by the physician, physician assistant, or nurse practitioner. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

_____ _____/_____/_____

Signature of Legal Guardian Date