Children's Health Services, P.A.
Pediatric & Adolescent Care

Patient Registration

Patient_____ Sex: ☐M ☐F DOB___/___/___ SS#_____ Race:_____

Mother/Guardian_____ DOB___/___/___ SS#_____

Address_____ Home phone_____
Cell phone_____
City/State/Zip_____ Occupation _____

Employer_____ Work phone_____
Cell phone _____
Father/Guardian_____ DOB___/___/___ SS#_____

Address_____ Home phone_____

City/State/Zip_____ Occupation _____

Employer_____ Work phone_____

Sibling_____ Sex : ☐M ☐F DOB___/___/___ SS#_____

Sibling_____ Sex : ☐M ☐F DOB___/___/___ SS#_____

Sibling_____ Sex : ☐M ☐F DOB___/___/___ SS#_____

Children live with: ☐Mother ☐Father ☐Guardian Preferred Email address:_____

Emergency Contact _____Relationship_____Phone_____

Insurance Information

Primary_____ Claims Address_____

Policy #_____ Group#_____ Copay_____

☐ **SELFPAY/NO INSURANCE (please speak with receptionist)**
****PLEASE NOTE YOU WILL BE ASKED FOR YOU INSURANCE CARD AT EVERY VISIT****

Authorization of Treatment and Assignment of Benefit

I authorize Children's Health Services, P.A. to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Children's Health Services, P.A. for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following:_____

_____ _____
SIGNATURE/RELATIONSHIP **DATE**

_____ _____
Witness' Signature **DATE**