

FAMILY REGISTRATION



THE CENTER FOR ADVANCED PEDIATRICS

Account# _____

Date ____/____/____

Parent _____ DOB ____/____/____ SS # _____
 Address _____ Home Phone _____
 City/State/Zip _____ Occupation _____ Cell Phone _____
 Employer _____ Work Phone _____ Email: _____
 Employer Address _____

Parent _____ DOB ____/____/____ SS # _____
 Address _____ Home Phone _____
 City/State/Zip _____ Occupation _____ Cell Phone _____
 Employer _____ Work Phone _____ Email: _____
 Employer Address _____

Parents are: Living Together Sperated Divorced If Divorced, who is the Custodial Parent _____

Child _____ Sex: Male Female DOB _____ Child _____ Sex: Male Female DOB _____
 Child _____ Sex: Male Female DOB _____ Child _____ Sex: Male Female DOB _____
 Child _____ Sex: Male Female DOB _____ Child _____ Sex: Male Female DOB _____

Emergency Contact Person: _____
 Relationship _____ Home Phone _____ Cell Phone _____

Names of individuals, and relationship, (other than parents) of persons whom I give permission to bring in my child and be responsible for carrying out the directives given to them by Advanced Pediatrics. Please note that the person bringing in the child is responsible for payment.

Name	Cell phone	Name	Cell phone

Who may we thank for referring you to us? _____

Insurance Information (you must provide us with a copy of your current insurance card)

Insurance Company _____ I.D. _____ Effective Date _____

Co-Pay \$ _____

Insurance provided through: Employer Private Other Self Pay Name of Insured _____

Name and full address of Employer _____

Note: You need to select one of our physicians as your primary care physician and notify your insurance of selection.

Please indicate name of physician shown on your card _____

Your preferred Pharmacy: _____ Location: _____ Pharmacy Phone: _____

Authorization of Treatment and Assignment of Benefits:

I authorize The Center for Advanced Pediatrics, to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to The Center for Advanced Pediatrics, for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Advanced Pediatrics for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits. I also understand that I am responsible for advising Advanced Pediatrics of any and all changes to my insurance. Payment of co-pays are due on date of service. Failure to pay co-pay at that time will result in an additional billing charge of \$25.00. Our office requires 24 hours notice of appointment cancellation. Failure to provide this notice will incur a cancellation fee.

Signature _____ Relationship _____ Date _____

A photocopy of this authorization shall be considered as effective and valid as the original.