Minor Patient Registration Form

Child's Name: _____ Date of Birth: ___/___/____
First Middle Last MM/DD/YEAR

If Student: [ ] Full Time [ ] Part Time Name of school: _____

Home Address: _____
Street Apt #

_____
City State Zip code

Legal Guardian/Parent Name: _____ Date of Birth: ___/___/____
First Middle Last MM/DD/YEAR

Social Security Number: _____ Gender: [ ] Female [ ] Male

Employer Address: _____ Work Number: _____

In order to establish optimal relations with our patients avoid misunderstanding regarding our payment policies, out staff is trained to inform you of the financial policies of this office. A payment is expected from you at the time of service for your part of the charges. We accept VISA and MASTERCARD for your convenience. Your signature authorizes the Doctor to release medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned is filed.

It is the policy of this office that the adult presenting the child is responsible for payment of the patient portion at the time of service.

_____ _____
Signature of Legal Guardian/Parent Date

Insurance Information:

Name of policy owner if not patient: _____

Relationship to the patient: [ ] Self [ ] Parent [ ] Other: _____

Should the account fall into the arrears greater than 60 days, I authorize that the unpaid balance to be charged to my major credit card.

Please present insurance cards and photo ID to the receptionist.

Do we have your permission to:

Leave a message on your answering machine? [ ] YES [ ] NO
Leave a message at your place of employment? [ ] YES [ ] NO
Discuss your child's medical condition with any other member of your household [ ] YES [ ] NO
If YES, whom: _____ Relation: _____

_____ _____
Signature of Legal Guardian/Parent Date