

REGISTRATION INFORMATION

Pediatrics

Date _____

Patient Name (Last, First, MI): _____

Telephone (Home): _____ Telephone (Cell): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: ____/____/____ Age: _____ Sex M F Social Security Number _____

Parents Names: _____

Employer: _____ Telephone Number: _____

Business Address: _____

Occupation: _____ Social Security Number (Mother): _____

Birthdate (mother): ____/____/____ Birthdate (Father): ____/____/____ SS# (Father): _____

Emergency Contact: _____ Phone #'s: _____

Your Drug Store Name: _____ Phone: _____

How did you hear of our practice? _____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I, _____, hereby authorize

_____ (Ins. Co.) to pay and hereby assign directly to Better Health Medical Center, Inc. all benefits, if any, otherwise payable to me for services as described above. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Better Health Medical Center, Inc. will be credited to my account, in accordance with the above assignment.

I agree by signing below that I will schedule follow-up and well child check appointments as deemed necessary by my physician. I also agree should the need arise to reschedule or cancel said appointments I will give at least a 24 hour notice or I may incur a \$25.00 missed appointment fee.

Parent/Legal Guardian

Date