ROCKDALE PEDIATRICS

PATIENT REGISTRATION (Please Print)

Name: _____ Date of Birth: _____/_____/_____
(Last) (First) (Middle)

Mailing Address: _____ Social Security #: _____-____-_____
(Street or P.O. Box) (City) (State) (Zip code)

Mobile #: ( )_____ Home # (optional): ( ) _____ Check one: ☐ Male ☐ Female ☐Other

Parent / Guardian Information: **EMAIL:**_____

MOTHER_____ DOB:_____ SS#_____-_____-_____

Address: _____ Employer: _____

Phone #: ( )_____ Cell#:( )_____ Work#:( )_____

FATHER: _____ DOB:_____ SS#_____-_____-_____

Address: _____ Employer:_____

Phone #: ( )_____ Cell#: ( )_____ Work#: ( )_____

Please be advised if your child's insurance is inactive you must pay for their visit at the time of service!

INSURANCE INFORMATION*

Primary

Insurance Carrier: _____
Policyholder's Name: _____
Policyholder's Date of Birth: _____
Policyholder's Employer: _____
Relationship to Patient: _____
Insured Party ID# or SS#: _____

Secondary

Insurance Carrier: _____
Policyholder's Name: _____
Policyholder's Date of Birth: _____
Policyholder's Employer: _____
Relationship to Patient: _____
Insured Party ID# or SS#: _____

*PLEASE PROVIDE **ALL** ACTIVE INSURANCE POLICIES FOR YOUR CHILD
IF THE PATIENT HAS MEDICAID BUT ALSO HAS A PRIVATE INSURANCE, THE PRIVATE INSURANCE MUST BE FILED AS PRIMARY

Has any member of your family been seen as a patient in this office? ☐ Yes ☐ No If yes, please list their name(s):

_____

Nearest friend or relative not living in the same household: _____
Relationship to patient: _____ Phone #: ( ) _____

I have completed this form accurately, truthfully, and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. **Office Policy:** I understand and agree that I will be responsible for any balances not covered by my insurance company regardless of who the insurance policyholder is. If my account balance is 30 days past due, I agree that I will be assessed a monthly $10 fee/rebilling fee. If my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees (35%), attorney fees, court costs, etc. Any NSF/returned checks will be assessed a $35 fee. I understand there is a $10 fee for all forms and letters. 3231,3300 and sport physical forms are $10 if requested 30 after the well exam date. Parent or legal guardian must be present with child at their first appointment, no exceptions and they must stay for the duration of initial visit. Anyone over the age of 18 can accompany a patient to an appointment after the initial visit if they have written consent from their parent or legal guardian. Anyone accompanying a patient to an appointment must present their picture ID.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize ROCKDALE PEDIATRICS HEALTHCARE, P.C. and its affiliates to release information contained in my medical record for the purposes of treatment, payment and operations as follows: 1) To my Insurance company(s), their agents, or third party payer, and/or government or social services agencies which may or will pay for any part of my medical care; 2) As mandated by law; 3) To alternate care providers, including community agencies and services, as ordered by my physician or as requested by me or my family for my care.

CONSENT TO TREATMENT: I hereby request and voluntarily authorize ROCKDALE PEDIATRICS HEALTHCARE, P.C. and its designated physicians and staff to provide and perform such medical care, tests, procedures, medications and other services as deemed advisable or necessary in my diagnosis and treatment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the results of the treatments, examinations, or medical care at Rockdale Pediatrics Healthcare. I understand this authorization includes treatment of minors who may not be accompanied by a parent or guardian unless I have otherwise stated.

Date:_____ Signature of Patient: _____Signature of Parent/Guardian:_____