New Beginnings Pediatrics

Acct. #_____

Registration
Please Print
Date: _____

Child(s) Doctor_____

Guarantor Information (Responsible for Account):

Last Name_____ Home Phone_____

First Name_____ Work Phone_____

Street Address_____ Cell Phone_____

City_____ State_____ Date of Birth_____

Zip Code_____ Sex (M/F) _____ Social Security #_____

Employer_____ Marital Status: Single Married Other

Address_____

City_____ State_____ Zip Code_____

Dependent Information: (Children only) (Any child under 18 please list hospital of birth)

Full Name_____ DOB_____ SSN#_____

Hospital of Birth_____ Mother's Full Name at time of birth_____

Full Name_____ DOB_____ SSN#_____

Hospital of Birth_____ Mother's Full Name at time of birth_____

Full Name_____ DOB_____ SSN#_____

Hospital of Birth_____ Mother's Full Name at time of birth_____

Full Name_____ DOB_____ SSN#_____

Hospital of Birth_____ Mother's Full Name at time of birth_____

Medical Insurance:
Guarantor Information (Person Responsible for Insurance)

Name of Primary Insurance_____

Last Name_____ Home Phone_____

First Name_____ Work Phone_____

Street Address_____ Date of Birth_____

City_____ State_____ Social Security #_____

Zip Code_____ Sex (M/F) _____ Co-pay Amount _____

Employer Name_____

Relationship to Patient_____

Signature _____ Date:_____
(Patient or Parent/Guardian if Minor)

Please Complete Reverse Side

Assignment of Benefits

Insurance Patients:

I authorize the release of any medical or other information necessary to process a medical claim. I also authorize payment to be made to New Beginnings Pediatrics for any services provided to me or my dependent by the physician.

_____ _____

Signature (Patient or parent/guardian of minor) Date

Emergency Contact:

In the event of an emergency, please list the party you would like contacted.

Name_____ Relationship to Patient_____

Home Phone_____ Work Phone_____

Payment Agreement:

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor to bill my insurance on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment in full, upon receipt of monthly statement. NOT APPLICABLE TO HMO PATIENTS ASSIGNED TO NEW BEGINNINGS PEDIATRICS AS PCP.

Signature_____ Date_____

(Patient or parent/guardian of minor)

Coordination of Care:

I authorize the release of information to a physician specialist to coordinate medical care.

Signature_____ Date_____

(Patient or parent/guardian of minor)

I give my permission for _____ to seek medical care for my child(ren) in my absence. This includes the treatment of an acute illness and/or a scheduled well child examination including immunizations.

Signature_____ Date_____

(Patient or parent/guardian of minor)