PEDIATRIC PATIENT REGISTRATION FORM

Child's first name	Last Name	Birthday	Sex	Nickname

Mother's Name ____

Date of Birth ___________________ SS#________________________

Home Address _______________________________________City ______________Zip______________

Occupation ___________________________ Place of Employment_________________________________

Work Phone _________________ Ext_____ Single ( ) Married ( ) Divorced ( ) Widowed ( )

Father's Name ____

Date of Birth ___________________ SS#________________________

Home Address _______________________________________City ______________Zip______________

Occupation ___________________________ Place of Employment_________________________________

Work Phone _________________ Ext______ Single ( ) Married ( ) Divorced ( ) Widowed ( )

Legal Guardian: Name__________________________ Relation____________ Phone________________

If Divorced – Person or Persons having legal custody ____

Emergency Contact: Name________________________ Relation____________ Phone________________

I authorize the individuals listed below to be involved in my children's medical treatment, including bringing them in for visits.

___________________________ _____________________________

Name and Relationship Name and Relationship

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Parent or Legal Guardian Signature

** Any Individual obtaining care on your behalf for your child must be over the age of 18.

Insurance Information (Please give your insurance(s) and Photo ID to the receptionist):

Primary Insurance Company's Name ____

Policy Holder's Name ____

Member ID # _____________________________ Group # __________________Date of Birth___________

Secondary Insurance Company's Name ____

Policy Holder's Name ____

Member ID # _____________________________ Group # __________________Date of Birth___________

Insurance Assignment and Releases

I, the undersigned, hereby assign, transfer and set over to Mountain View Internal Medicine & Pediatrics all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from medical and/or surgical services performed for me by Mountain View Internal Medicine & Pediatrics and I direct my insurance company to pay any and all such entitlements directly to Mountain View Internal Medicine & Pediatrics.

____ ___________________________

Parent or Legal Guardian Signature Date

I authorize Mountain View Internal Medicine & Pediatrics to render medical care to my child**. I understand that all co-pays and deductibles are to be paid at the time of service.** In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I agree to pay any and all costs of collection including attorney's fees. In the event that my child is hospitalized, I authorize the release of any medical information necessary to process an insurance claim and I authorize payment of medical benefits directly to Mountain View Internal Medicine & Pediatrics. I understand that my insurance policy is a contract between my insurance company and myself and that I am financially responsible for charges not covered by the policy. I will assist in the collection of my insurance benefit should there be any delay on payment.

I have received the attached "Notice of Privacy Policy" detailing how my information may be used and disclosed as permitted under federal and state law, and a copy of the office financial policy.

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Parent or Legal Guardian Signature Date