

**PROFESSIONAL PEDIATRICS
REGISTRATION FORM**

508 Gibson Dr., Ste. 220
Roseville, CA 95678
(916) 773-5577

Patient Information

(Please Print)

Patient Name: _____ Date: _____

Sex: M F Age: _____ DOB: _____

Mother/Guardian Name: _____

SSN: _____ DOB: _____

Driver's License #: _____ E-Mail: _____

Address: _____

City: _____ CA: _____ Zip: _____

Primary Phone: () _____ Cell Phone: () _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ CA: _____ Zip: _____

Father/Guardian Name: _____

SSN: _____ DOB: _____

Driver's License #: _____ E-Mail: _____

Address: _____

City: _____ CA: _____ Zip: _____

Primary Phone: () _____ Cell Phone: () _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ CA: _____ Zip: _____

Siblings Names/DOB/Sex: _____

Emergency Contact Name (not living with you): _____

Relation to patient: _____

Phone: () _____ - _____ Alternate Phone: () _____ - _____

Referring Physician: _____ Phone: () _____ - _____

Race Decline to report American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Black or African American
 White Hispanic Other Race _____

Insurance Information

Primary Insurance Company: _____

Phone: () _____ - _____ Type of Insurance (circle one) HMO PPO POS Other

Primary Insured's Name: _____ Relationship to Patient: _____

ID#: _____ Group#: _____ Effective Date: _____

ASSIGNMENT & RELEASE

I the undersigned certify that I (or my dependent) have insurance coverage as above and assign directly to Professional Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

PRIVACY POLICY

At Professional Pediatrics we are committed to ensuring patient privacy and confidentiality. Please sign below to indicate that you the responsible party, have had an opportunity to read and understand our privacy policy.

Responsible Party Signature

Relationship

Date