

FORT WORTH PEDIATRICS

Chart #: _____

PATIENT REGISTRATION

Account #: _____

Patient Name: _____ Social Security # _____
(First) (Middle) (Last)Address: _____
(Street) (Apt #) (City & State) (Zip)Date of Birth: _____ Age _____ Gender Male Female

Parent/Guardian Name: _____ Phone: _____ Cell: _____

Primary Care Physician: _____ Referred By: _____

Have any other children been seen in this office? No Yes, Names: _____

Parent or Guardian Information

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Social Security # _____ DOB: _____ Social Security # _____ DOB: _____

Driver's License #: _____ Driver's License #: _____

Address: _____ Address: _____

Home # _____ Work # _____ Home # _____ Work # _____

Employer: _____ Employer: _____

Insurance Information

Primary Insurance Company: _____ Secondary Insurance Company: _____

Name of Person Who Carries Ins: _____ Name of Person Who Carries Ins: _____

Insured's Date of Birth: _____ Insured's Date of Birth: _____

Telephone: _____ Telephone: _____

Insurance Co. Address: _____ Insurance Co. Address: _____

Member ID # _____ Group # _____ Member ID # _____ Group # _____

Group/Employer Name: _____ Group/Employer Name: _____

Emergency Contact Information

Name of Person to Notify in Case of Emergency: _____
(other than the parents)

Telephone #: _____ Relationship: _____

CONSENT TO TREAT:

I hereby give my permission to the Physician in charge of my child(ren) and Staff as he/she or they may designate, to perform and administer all treatments and diagnosis which in their judgment may be considered necessary or advisable for my child(ren)'s well being.

RELEASE OF INFORMATION:

I hereby authorize Fort Worth Pediatrics and Agents in charge of the care of my child(ren) to release information contained in my child(ren)'s medical records to the insurance companies, or independent contracts thereof, for the purpose of processing my claims for insurance benefits.

FINANCIAL AGREEMENT:

The Undersigned hereby agrees that in consideration for services rendered, payment of the accounts is guaranteed in accordance to the regular rate and terms of Fort Worth Pediatrics. The Undersigned clearly understands that payment obligation is the responsibility of the patient and parent or guarantor.

ASSIGNMENT OF BENEFITS:

I hereby assign to Fort Worth Pediatrics and Agents associated with the care and treatment of my child(ren) any interest and benefits provided under my insurance policy or policies. I also understand that any balance not covered by insurance are due and payable by myself.

Signature: _____

Date: _____