Phillips Pediatrics

Family Registration Form

Previous PCP (if any): ☐ Dr. Phillips ☐ Other: ________________________			Today's Date:____/______/________

FAMILY/CONTACT INFORMATION

Parent #1:	DOB: _____/_____/_______	Mobile #:	
Email:		Alt Phone #:	
Address:	City:	State:	Zip:
Parent #2:	DOB: _____/_____/_______	Mobile #:	
Email:		Alt Phone #:	
Address:	City:	State:	Zip:

Patient resides primarily with: ☐ Both Parents ☐ Mother ☐ Father

☐ Legal Guardian:___________________________________ ☐ Other:____________________________

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Other:____________________________

If divorced, who is the Custodial Parent: ☐ #1 ☐ #2 ☐ Joint

The best way to reach me is: ☐ Cell Phone # ☐ Atl Phone # ☐ Email

PATIENT(S) INFORMATION

Child:		DOB: _____/_____/_______	Sex: ☐ M ☐ F
Nickname:	Medicaid # (if applicable):	Race:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Child:		DOB: _____/_____/_______	Sex: ☐ M ☐ F
Nickname:	Medicaid # (if applicable):	Race:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Child:		DOB: _____/_____/_______	Sex: ☐ M ☐ F
Nickname:	Medicaid # (if applicable):	Race:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Child:		DOB: _____/_____/_______	Sex: ☐ M ☐ F
Nickname:	Medicaid # (if applicable):	Race:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic

EMERGENCY CONTACTS (OTHER THAN PARENTS)

Name (First, Last):	Relationship to patient:	Mobile #:
Address – City, State, Zip:		Alt. Phone #:

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INSURANCE INFORMATION		
(Please give your insurance card to the front desk)		
Is this patient covered by insurance? ☐ Yes ☐ No (Self-Pay)		
Name of Primary Insurance Company:		Co-Pay:
Group #:	Policy #:	Effective Date: ____/_____/_____
Subscriber's Name:	DOB: ____/_____/_____	Sex: ☐ M ☐ F
Address:		Mobile #
Employer:		Employer Phone:
Employer Address:		
Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Other		
Name of secondary insurance (if applicable):		Co-Pay:
Group #:	Policy #:	Effective Date: ____/_____/_____
Subscriber's Name:	DOB: ____/_____/_____	Sex: ☐ M ☐ F
Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Other		

PHARMACY INFORMATION		
Pharmacy Name:	Address:	Phone #:

HOW DID YOU FIND US? PLEASE CHECK ONE:

How did you find us? Please check one:

☐ Insurance Plan ☐ Internet/Social Media ☐ Referred by:_____.

☐ Family/Friend:_____ ☐ Other:_____ ☐ Close to home

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize **Phillips Pediatrics, LLC**, to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to **Phillips Pediatrics, LLC**, for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse **Phillips Pediatrics, LLC** for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits. I also understand that I am responsible for advising **Phillips Pediatrics, LLC** of any and all changes to my insurance. Payment of co-pays are due on date of service. Failure to pay co-pay at that time will result in an additional billing charge as outlined in our Financial Policy. Our office requires 24 hours' notice of appointment cancellations. Failure to provide this notice will incur a cancellation fee. **PLEASE SEE FINANCIAL POLICY**.

_____ _____

Patient/Guardian Signature Date

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