

PEDIATRIC REGISTRATION FORM

Today's Date _____
Child's Full Legal Name _____ Gender M F
Birth Date _____ Social Security # _____ Telephone _____
Address _____

Race: B H I M P R S U W
Key: B – Black/African American H – Hispanic I – American Indian/Alaskan Native/Eskimo M – Multi-racial
P – Pacific Islander R – Refused S – Asian U – Unavailable W - White

Mother's Name _____ Social Security # _____ DOB: _____
Address _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Employer _____ Occupation _____

Father's Name _____ Social Security # _____ DOB: _____
Address _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Employer _____ Occupation _____

Email (optional) _____

RESPONSIBLE PARTY IF OTHER THAN PARENT LISTED ABOVE

Name _____ Birthdate _____ Relationship _____
Address _____
Home Phone # _____ Work Phone # _____ Employer _____

MEDICAL INSURANCE

Primary Insurance _____	Secondary Insurance _____
Subscriber _____	Subscriber _____
ID or Policy # _____	ID or Policy # _____
Group # _____ Plan # _____	Group # _____ Plan # _____
Effective Date _____	Effective Date _____

BROTHERS/SISTERS

Name _____	DOB: _____	Race _____	Gender	M	F
Name _____	DOB: _____	Race _____	Gender	M	F
Name _____	DOB: _____	Race _____	Gender	M	F

All professional services rendered are charged to the parent. Payment is due at time of service unless it is covered by an insurance in which we participate..

I hereby authorize Dr. Rice to furnish information to insurance carriers concerning my child's illness and treatments.

I also authorize any insurance payment due to the physicians/providers to be paid directly to Dr. Rice.

Some services, including but not limited to well visits, sports pre-participation physicals, forms completion, after hours phone triage calls, and immunizations may not be covered by my insurance. I understand that I am responsible for any amount not covered by insurance.

Date: _____ Parent's Signature: _____

