

**GROWING CHILD PEDIATRICS, PA  
PATIENT REGISTRATION FORM 2010**

<b>PATIENT INFORMATION</b>				
Last Name		First Name		Initial
DOB		SSN		Male / Female
<b>MOTHER/ Guardian</b>	Last Name	First Name		Initial
Address		City	State	ZIP
Employer		SSN	E-Mail	
DOB	Work Phone	Cell Phone	Home Phone	
<b>FATHER/ Guardian</b>	Last Name	First Name		Initial
Address		City	State	Zip
Employer		SSN	E-Mail	
DOB	Work Phone	Cell Phone	Home Phone	
<b>PRIMARY INSURANCE NAME</b>			<b>Effective Date</b>	
Insurance Company Address				
Policy Holder's Name			Date of Birth	
Policy Holder's SSN		Subscriber ID#		Group #
<b>SECONDARY INSURANCE NAME</b>			<b>Effective Date</b>	
Insurance Company Address				
Policy Holder's Name			Date of Birth	
Policy Holder's SSN		Subscriber ID#		Group #
<b>SIBLING NAME</b>		Date of Birth		Social Security Number
<b>EMERGENCY CONTACT (OTHER THAN PARENT)</b>		Name		
Phone #'s		Relationship		
<b>PLEASE INDICATE HOW YOU HEARD ABOUT US: GCP Website <input type="checkbox"/> Fast Braiin Website <input type="checkbox"/> School <input type="checkbox"/> Friend <input type="checkbox"/></b>				
<b>Advertisement <input type="checkbox"/> Where? _____ Other Doctor's Office <input type="checkbox"/> Phone Book <input type="checkbox"/> Insurance or Medicaid <input type="checkbox"/> Drove By <input type="checkbox"/></b>				
I understand that payment is expected at the time of service. However, in the event that Growing Child Pediatrics files for me (I.E., HMO, PPO, Medicaid) I authorize payment of all benefits to Growing Child Pediatrics. <b><u>Per my insurance contract, failure to pay my copay at the time of visit may be grounds for dismissal from my health plan.</u></b> I also authorize Growing Child Pediatrics and/or the rendering physician(s) to release all medical information required by my insurance company to file for medical benefits. <b><u>I agree to pay Growing Child Pediatrics in full if I or Growing Child Pediatrics is not able to contact my insurance company to verify coverage, or if my insurance company fails to cover services rendered.</u></b> Growing Child Pediatrics will structure a payment plan suitable to both parties. If my insurance company does respond with coverage at a later date, I am aware that Growing Child Pediatrics will reimburse my overpaid portion. <span style="float: right;">O26-Rev 10/09</span>				
Signature		Date		