

## Pediatric Physicians, Inc. REGISTRATION FORM

Today's date:				Pediatrician:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status if applicable (circle one) or student? Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Cell phone no:		Home phone no: (    )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no: (    )		
Chose practice because/Referred to practice by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members/siblings seen here:							
<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no: (    )	
Is this person a guarantor for more than one patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Sibling Names:			Cell Phone (    )		
Occupation:	Employer:	Employer address:			Employer phone no: (    )		
Is this person covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective Date of Insurance?					
Please indicate primary insurance		<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Anthem	<input type="checkbox"/> Medical Mutual of Ohio	<input type="checkbox"/> Aetna	<input type="checkbox"/> CIGNA	
<input type="checkbox"/> Caresource	<input type="checkbox"/> Medicaid	<input type="checkbox"/> OSU	<input type="checkbox"/> HSA High Deductible		<input type="checkbox"/> Other		
Subscriber's Legal name:		Subscriber's S.S. no:	Group Name:	Group no:	Policy no:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	<input type="checkbox"/> Step Parent	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no:	Policy no:		
Address:		Date of Birth / /		Social Security #	Eff. Date: / /		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>IN CASE OF EMERGENCY</b>							
Leave a message at home with other residents? Y_____ N_____ Answering machine/Voice Mail? Y_____ N_____							
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone : (    )	Work phone: (    )		
I understand and request that payment of authorized insurance company benefits be made directly to Pediatric Physicians, Inc. on my behalf for all rendered services. I authorize any holder of medical information about me to release information needed to determine these benefits or the benefits payable to related services. I am responsible for any co-pay, co-insurance, and deductible or non-covered amounts.							
_____ <i>Patient/Guardian signature</i>				_____ <i>Date</i>			