SILVERLAKE PEDIATRIC CLINIC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____
Last First Middle

Date of Birth: _____ **Age:** _____ **Sex:** M / F **Social Sec. #:** _____

Address: _____
Street City State Zip

Father's Name: _____ **DOB:** _____

Address: _____

Employer: _____ **WK Ph:** _____

Social Sec. #: _____

Mothers's Name: _____ **DOB:** _____

Address: _____

Employer: _____ **WK Ph:** _____

Social Sec. #: _____

Home Telephone#: _____ **Cell Telephone#:** _____

Emergency Contact Person: _____ **Telephone#:** _____

Relationship To Pt.: _____

How did you hear about us? _____

INSURANCE INFORMATION

PRIMARY INSURANCE - Effective: ____/___/____	SECONDARY INSURANCE - Effective: ____/___/____
Insurance Co. Name: _____	**Insurance Co. Name:** _____
Group/ Plan # _____	**Group/ Plan #** _____
Policy/Member # _____	**Policy/Member #** _____
Subscriber Name: _____	**Subscriber Name:** _____

The above information is true to the best of my knowledge. I authorize treatment for myself or the above individual and I understand that I am ultimately responsible for charges associated with medical services and agree to pay all bills within 30 days from receipt of a statement, unless other arrangements are made. I authorize the physician and the clinic to release any information required to process my insurance claims. I understand that my medical record may contain information regarding HIV/AIDS, substance abuse, mental health, sexually transmitted diseases, sickle cell anemia, or other sensitive information. I also authorize my insurance to directly pay the Silverlake Pediatric clinic.

Please Initial _____

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitle to receive a copy of this document.

Please Initial _____

Payment Policy

CONTRACTED INSURANCE: All contracted insurance companies are billed directly as a courtesy. Any remaining balance for non-covered benefits and deductibles are your responsibility. Payment for this is expected within 30 days from receipt of your statement. Co-Pays and any applicable Deductible payments are expected at the time service is rendered.

NON-CONTRACTED INSURANCE: If your insurance company is not contracted with The Clinic all charges are considered patient responsibility at the time of service. As a courtesy, the clinic will provide you with a claim to send to your insurance for reimbursement. All **Third Party Payers** (motor vehicle accident insurance) are considered non-contracted

Please Initial _____

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Patient/Responsible Party Signature Date