Ad-Park Pediatrics S.C.
Patient Registration Form

WELCOME TO OUR OFFICE!

Parent Information			
Parent #1		Parent #2	
Name:	DOB:	Name:	DOB:
Address:		Address:	
City: State: Zip:		City: State: Zip:	
Employer:		Employer:	
Home phone:		Home phone:	
Cell phone:		Cell phone:	
Work phone:		Work phone:	
Email:		Email:	

Patient Information			
Child 1	Name:	DOB:	Sex : ____Male ____Female
Child 2	Name:	DOB:	Sex : ____Male ____Female
Child 3	Name:	DOB:	Sex : ____Male ____Female
Child 4	Name:	DOB:	Sex : ____Male ____Female
Child 5	Name:	DOB:	Sex : ____Male ____Female
Child 6	Name:	DOB:	Sex : ____Male ____Female

Insurance Information			
Primary Coverage		Secondary Coverage (if applicable)	
Subscriber:		Subscriber:	
Insurance Carrier(ex: BCBS,Aetna,ect.): ____PPO____HMO___POS		Insurance Carrier(ex: BCBS,Aetna,ect.): ____PPO____HMO___POS	
Policy #:	Group #:	Policy #:	Group#

Pharmacy Information		
Pharmacy name:	Address:	Phone #
		Fax#

Emergency Contact		
Name:	Relative type:	Phone #:

Miscellaneous Information
Do we have permission to leave messages for labs, x-rays, results? _____ YES _____NO Phone#:

GENERAL FINANCIAL POLICY:

-I understand I am fully responsible for all charges incurred at Ad-Park Pediatrics Assoc. S.C. relating to the care of my family, regardless of insurance company coverage. I understand that there is a $25.00 fee if I fail to show up for an appointment or if I fail to cancel my appointment within 24 hours of the scheduled time. I understand that I am responsible for additional collection expenses incurred at Ad-Park Pediatrics Assoc. S.C. if my account becomes delinquent. This includes but is not limited to a 35% collection fee and/or attorney fees.

-You are responsible for knowing the benefits of your insurance policy. If you do not want a vaccine or procedure performed you must inform the practice in advance. All charges that are covered or not covered by your insurance are your responsibility.

RELEASE AUTHORIZATION:

-I also authorize Ad-Park Pediatrics Assoc. S.C. to release any requested information obtained in the course of examination and treatment to the appropriate insurance company. I understand I have the right to withdraw this permission upon written notice to Ad-Park Pediatrics Assoc. S.C.

☐I have read and accept the above terms and conditions

Signature:_____ Date:_____