

MAIN STREET PEDIATRICS, LLC
Registration Form

All information must be completed in order to bill your insurance carrier. If the information is not received at the time of service, you will be responsible for the bill.

Today's Date: _____

Account Number: _____

A. Patient Information:

Primary Care Physician: _____

Patient Name _____

Date of Birth (DOB) _____ M F

Address _____

City _____ State _____ Zip _____

Telephone _____

Social Security # _____

Siblings (list all) Children live with: Parents Mother Father Other

Name _____	DOB _____	Sex _____	SS# _____	-	-
Name _____	DOB _____	Sex _____	SS# _____	-	-
Name _____	DOB _____	Sex _____	SS# _____	-	-
Name _____	DOB _____	Sex _____	SS# _____	-	-

Parent Information

Father's Name _____

Mother's Name _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Telephone (h) _____ (w) _____

Telephone (h) _____ (w) _____

Employer _____ Occupation _____

Employer _____ Occupation _____

Social Security # _____ DOB _____

Social Security # _____ DOB _____

B. Insurance Information: (PLEASE ALSO ATTACH FRONT/BACK COPY OF ID CARD)

Primary Policy Holder _____

Secondary Policy Holder _____

Insurance Co. _____

Insurance Co. _____

Ins Address _____

Ins Address _____

Policy # _____

Policy # _____

Group # _____ Effective Date _____

Group # _____ Effective Date _____

Employer _____

Employer _____

Relationship to Patient _____

Relationship to Patient _____

Social Security # _____ DOB _____

Social Security # _____ DOB _____

C. Financially Responsible Party: (IF OTHER THAN POLICY HOLDER)

Name: _____ Date of Birth: _____ SSN: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____ H# _____ - _____ - _____ W# _____ - _____ - _____

D. Assignment of Benefits: I understand that I am responsible for the accuracy of the information I have provided on this form. I authorize payment of medical and/or surgical benefits directly to Main Street Pediatrics, LLC, for all services rendered. I also authorize release of any medical and/or other information necessary for the processing of claims. If for any reason payment may not be made by my insurance carrier, I will be held responsible for all fees incurred with Main Street Pediatrics, LLC as well as all costs associated with any collection agencies and/or attorney fees.

I have received the Main Street Pediatrics Notice of Privacy Practice as it relates to my child or me as defined by state and federal regulations.

In addition, I understand that the parent who brings the child to the office for medical services is responsible **AT THE TIME OF SERVICE** for co-payments, deductibles, balances and for payment in full if the provider of service is non participating with my insurance carrier.

Patient/Parent/Legal Guardian Signature

Date