MAIN STREET PEDIATRICS

Registration Form

All information must be completed in order to bill your insurance carrier. If the information is not received, and correct, 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 _____

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

Name _____ DOB_____ Sex_____

Name _____ DOB_____ Sex_____

Name _____ DOB_____ Sex_____

Name _____ DOB_____ Sex_____

Parent Information

Parent's Name_____
Address _____
City_____ State____ Zip _____
Telephone (h)_____ (w)_____
Employer_____ Occupation _____
Social Security #_____ DOB_____

Parent's Name_____
Address _____
City_____ State____ Zip _____
Telephone (h)_____ (w)_____
Employer_____ Occupation _____
Social Security #_____ DOB_____

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

Primary Policy Holder _____
Insurance Co._____
Ins Address _____
_____
Policy #_____
Group #_____ Effective Date_____
Employer _____
Relationship to Patient _____
Social Security #_____ DOB_____

Secondary Policy Holder_____
Insurance Co. _____
Ins Address _____
_____
Policy #_____
Group #_____ Effective Date_____
Employer _____
Relationship to Patient _____
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 the form. I authorize payment of medical and/or surgical benefits directly to Main Street Pediatrics 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 as well as all cost 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 or person 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.

The assignment of benefits remains in effect while you or your child/children are a patient of MSP including if/when your insurance carrier or benefits change. **The assignment of benefits must be revoked in writing.**

_____ _____

Patient/Parent/Legal Guardian Signature Date