2016 Patient Registration

Woodstock Pediatric Medicine

***All sections must be completed before services can be provided to your child.**

Woodstock Pediatric Medicine requires that a yearly, updated Patient Registration form be on file for your child .

Failure to complete this form may result in services being denied.

Thank you for cooperation!

Patient Information

Date:______________________ How did you first hear about us?______________________

Patient Name:______________________

Date of Birth:______________________ Sex: _______Male _______Female

With Whom Does the Patient Live?______________________ Address:______________________

City:______________________ State:__________ Zip Code:__________ Home Telephone:______________________

Sibilings who visit this office:

Name	Sex (M/F)	DOB (mm/dd/yy)

IN CASE OF EMERGENCY

Name:______________________ Relationship:______________________ Phone:______________________

Name:______________________ Relationship:______________________ Phone:______________________

Parent Information

Marital Status of Parents: _______Married _______Divorced or Divorce Pending _______Single(never married)

Mother's Name:______________________ Date of Birth:______________ SSN:______________

Contact E-Mail Address:______________________

Home Adress (if different from child):______________________

City:______________________ State:______________ Zip Code:______________

Home Telephone:______________ Cell Number:______________ Work Number:______________

Employer:______________________

Father's Name:______________________ Date of Birth:______________ SSN:______________

Contact E-Mail Address:______________________

Home Adress (if different from child):______________________

City:______________________ State:______________ Zip Code:______________

Home Telephone:______________ Cell Number:______________ Work Number:______________

Employer:______________________

Insurance Information

Primary Insurance Name:______________________ Effective Date:______________

Address:______________________

City:______________________ State:__________ Zip Code:__________ Phone No.:______________

Who is the Policy Holder?:______________________ Date of Birth:______________ SSN:______________

Relationship to Policy Holder:______________ Policy Type: _____HMO _____PPO _____POS Other:______________

Patient's Member ID Number:______________ Group Number:______________Co-Pay Amount:______________

Secondary Insurance Name:______________ Member ID Number:______________ Group Number:______________

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understnad that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Woodstock Pediatric Medicine, P.C. to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Woodstock Pediatric Medicine, P.C.

I give my consent for WOODSTOCK PEDIATRIC MEDICINE, P.C. to examine and treat as/of patient.

A photocopy of this authorization shall be considered as effective and valid as the original.

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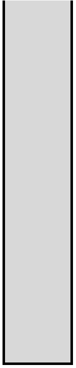
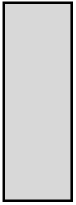
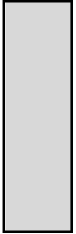
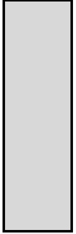
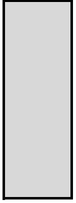
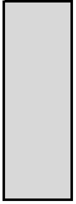
Parent/Guardian Signature **Parent/Guardian Printed Name**

****Return this form to a staff member before leaving the office. Thank you.****



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__________Co-Pay Amount:____

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