Patient Registration

Woodstock Pediatric Medicine

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

WPM <u>requires</u> this form to be completed yearly to continue providing services to your child.

Failure to complete this form completely or stating "Same" may result in services being denied. Thank you for your cooperation!

Patient Information

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

Patient Name:_____

Date of Birth:_____ Sex: _____Male _____Female

Preferred Language:_____ Race:_____ Ethnicity:_____ Hispanic/Latino Not Hispanic/Latino (circle)

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/Guardian Information

Marital Status of Parents/Guardian: _____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

Primary Insurance Name:_____ Effective Date:_____

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, *<u>REGARDLESS OF MARITAL STATUS</u>*. I understand 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 patient.

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

_____

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

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