Pediatric

Patient Registration

Date______________________

(Please print)

Patient's Full Name____DOB_______/_______/_______

Age______ Gender: M F Non-Binary **Cell Phone** __________________Home Phone____________________________

Address____City________________State ___________Zip____________

Please list all legal guardians for this patient:____
Relationship to patient:_______________________

Parents' marital status: Married Separated Divorced Domestic Partners

Parent____**Social Security#**_________-__________-________

Address (if different from above)____

Employed by:________________________________Business Phone:______________________Occupation:________________

Parent:____**Social Security#**_________-__________-_______

Address (if different from above)____

Employed by:________________________________Business Phone:______________________Occupation:________________

Parents e-mail:____

Pediatrician's Name____Phone:_________________________

Referred by:____

In an emergency, please contact:

____Phone____________________

Insurance Company:____

Subscriber.____**Date of Birth**______________________

Assignment of Duties

I hereby authorize Dr. Birns/Dr. Strocker to furnish to my insurance company all information that my insurance company may request concerning this illness or injury. I hereby assign to Dr. Birns/Dr. Strocker all payments to which I am entitled for medical and/or surgical expenses. I understand that I am financially responsible for all charges not covered by this assignment. A copy of this assignment is as valid as the original.

I hereby authorize Dr. Birns/Dr. Strocker to render whatever services are deemed necessary for the treatment of the above minor.

Date:__________________Signed: ____

(Signature of responsible party)

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