

Brighton Pediatric Center

Registration Form

| PATIENTS INFORMATION | | | | | | |
|--|----------------------|---|------------------------------|---|----------------|----------------|
| (Please list all children we will be caring for) | | | | | | |
| Last Name | First Name | MI | M/ F | DOB | Chart # | |
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| PARENTS INFORMATION | | | | | | |
| Home Street Address | | | City | State | Zip | Phone () - |
| Father's Name | Occupation/ Employer | | DOB / / | CELL PHONE () - | SSN - - | |
| Mother's Name | Occupation/ Employer | | DOB / / | CELL PHONE () - | SSN - - | |
| Guardian's Name | Occupation/ Employer | | DOB / / | CELL PHONE () - | SSN - - | |
| Emergency Contact (Other than Parents) | | | Relationship | | Phone () - | |
| INSURANCE & BILLING INFORMATION | | | | | | |
| Person Financially Responsible: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other | | | | Relationship: | | |
| PRIMARY INSURANCE: | | | SECONDARY INSURANCE: | | | |
| Subscriber's Name | | | Subscriber's Name | | | |
| Insurance ID | | | Insurance ID | | | |
| Group # /or Name of Employer | | | Group # /or Name of Employer | | | |
| Effective Date | | | Effective Date | | | |
| Address | | | Address | | | |
| PAYMENT REQUIRED AT TIME OF SERVICE- UNLESS PRIOR ARRANGEMENT HAS BEEN MADE | | | | | | |
| ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY | | | | | | |
| <p>The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform Brighton Pediatric Center of any changes in my minor's/ child's medical status. Insurance status, and / or financial status. Additionally, I will inform Brighton Pediatric Center of any address changes that may affect billing.</p> <p>I certified that my minor/ child is covered by the above insurance company/ companies, and I assign directly to Brighton Pediatric Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Brighton Pediatric Center, and doctors associated with Brighton Pediatric Center to release all information necessary to process a claim. I authorize the use of this signature on all my submissions, whether manual or electronic. <i>A photocopy of these assignments shall be as valid as the original</i></p> | | | | | | |
| Signature _____ Date ____/____/____ | | | | | | |
| HOW DID YOU HEAR ABOUT US | | | | | | |
| <input type="checkbox"/> Friend/ Relative _____ | | <input type="checkbox"/> Hospital _____ | | <input type="checkbox"/> Yellow Pages _____ | | |
| <input type="checkbox"/> Another Physician _____ | | <input type="checkbox"/> Insurance Co _____ | | <input type="checkbox"/> Internet _____ | | |
| <input type="checkbox"/> Other _____ | | | | | | |