# NEW PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Today's Date: _____/_____/_____

Patient Name: _____

Patient Date of Birth: _____/_____/_____

Patient Gender: _____ Male _____ Female

Permanent Address:

_____

## GUARANTOR INFORMATION

Mothers Name: _____

Address: _____

Mother Phone: _____ DOB: _____

Fathers Name: _____

Address: _____

Fathers Phone: _____ DOB: _____

## INSURANCE INFORMATION: PRIMARY

Name of Insurance: _____

Subscriber Name: _____

Subscriber Date of Birth: _____/_____/_____ SSN# _____

Relationship of Subscriber to Patient: ☐ Parent ☐ Other _____

Patient ID/Group #:_____

## INSURANCE INFORMATION: SECONDARY

Name of Insurance:_____

Subscriber Name: _____

Secondary Subscriber Date of Birth: ____/_____/_____ SSN# _____

Relationship of Subscriber to Patient: ☐ Parent ☐ Other _____

Patient ID/Group #:_____

**EMAIL ADDRESS:** _____

**PREFERRED PHARMACY/Location**: _____

_____

*Insurance claims will be filed on your behalf with correct insurance information.

☐ I hereby consent for Fox River Pediatrics S.C. to provide my child with medical treatment. I authorize the release of medical information contained in the child's medical chart to the insurance company in order to process any bills. I authorize the use and disclosure of the child's health information for the purposes of treatment, payment, and healthcare operations. I authorize payment from my, or the insured's insurance company directly to Fox River Pediatrics, S.C. Should my insurance company deny or not cover charges for any reason, I am financially responsible for the full amount of the bill. Should my account be referred to an outside collection agency, I agree to pay the collection fees.

_____ _____

Signature of Parent/Guardian Date