



MINOR/CHILD REGISTRATION
(PLEASE PRINT)

Today's Date _____

Home Phone _____

Mother's Cell Phone _____

Father's Cell Phone _____

PATIENT INFORMATION

Name of Minor/Child _____

Last Name

First Name

Initial

Sex [] M [] F Age _____ Birthdate _____ Nickname _____

Home Address _____

Street

City

State

Zip

Mailing Address _____

(if different from above)

Street

City

State

Zip

Person financially responsible _____

Whom may we thank for referring you? _____

INSURANCE COVERAGE

Father's/Guardian's Name _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Address (if different from patient's) _____

Work Phone _____

(if different from above)

Work Phone _____

(if different from above)

Email _____

Email _____

Employer _____

Employer _____

Soc. Sec # _____ Birthdate _____

Soc. Sec # _____ Birthdate _____

Do you have insurance coverage for minor/child? [] Yes [] No

Do you have insurance coverage for minor/child? [] Yes [] No

Plan Name _____

Plan Name _____

Ins. Phone # _____

Ins. Phone # _____

Address _____

Address _____

Group # _____ Policy # _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? [] Yes [] No Child's Medical Assistance Identification # _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

RELEASE AND ASSIGNMENT

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 this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Lake Shore Pediatrics 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 the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent/Guardian

Date