PATIENT REGISTRATION

Patient's Name: _____ _____ M/F: ____
Last First Middle Date of Birth

Address: _____
Street Apt # City State Zip

Other Children: Name: _____ M/F: ___ DOB: _____

_____ M/F: ___ DOB: _____

_____ M/F: ___ DOB: _____

_____ M/F: ___ DOB: _____

PARENT/GUARDIAN INFORMATION

Parent's Name: _____ Parent's Name: _____

DOB: _____ DOB: _____

Cell Phone: _____ Cell Phone: _____

Social Security #: _____ Social Security #: _____

E-Mail: _____ E-Mail: _____

Person Responsible for Payment: _____

Billing Address: _____
Street Apt # City State Zip

Emergency Contact Other Than Parents: _____

Relationship to Patient: _____ Phone #: _____

Primary Doctor (Circle One) Dr. Schorlemer Dr. Hieber Dr. Hanig
Dr. Fernandez Dr. Burns Dr. Shinn

INSURANCE INFORMATION

Insurance Company: _____ Policy Holder Name: _____

Policy or Subscriber #: _____ Group: _____

I authorize my insurance company to make payments to Clinical Pediatric Associates for my insurance claims. I also appoint Clinical Pediatric Associates to act as my authorized representative when requesting an appeal from my insurance company regarding its denial of service or payment.

Signature: _____ **Date:** _____

CONSENT TO TREAT PATIENT WITHOUT PARENT/LEGAL GUARDIAN PRESENT

I request and authorize Clinical Pediatric Associates and its personnel to deliver medical care to my child/children listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. Medical care and interventions may include but are not limited to: medical evaluation, physical exam, routine immunizations, injections, and lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, and suturing of lacerations). I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service. I have read, understand, and give my consent as stipulated above.

Signature: _____ **Date:** _____