WELCOME TO THE OFFICE OF SAN ANTONIO PEDIATRIC ASSOCIATES, P.A.

PATIENT REGISTRATION

DATE:

PATIENT'S INFORMATION				
Name:			Gender:	DOB:
Address:	City:		St:	Zip:
Home #:		Referred By:		
Name of your Pharmacy:		Phone:		
MOTHER'S INFORMATION				
Mom's Name:			DOB:	SS#
Address:	City:		St:	Zip:
Employer:			Occupation:	
Work Number:			Home Number:	
Landlord's Name:			Phone:	
FATHER'S INFORMATION				
Dad's Name:			DOB:	SS#
Address:	City:		St:	Zip:
Employer:			Occupation:	
Work Number:			Home Number:	
Landlord's Name:			Phone:	
GUARDIAN'S INFORMATION				
Name:			DOB:	SS#
Address:	City:		St:	Zip:
Employer:			Occupation:	
Work Number:			Home Number:	
Landlord's Name:			Phone:	
EMERGENCY CONTACT (OTHER THAN PARENTS)				
Name:		Address/Phone:		
CLOSEST RELATIVE (NOT LIVING WITH FAMILY)				
Name:		Address/Phone:		
INSURANCE/BILLING INFORMATION				
Responsible person: ☐ Father ☐ Mother ☐ Other:				
Billing Address:				Phone:
PRIMARY INSURANCE				
Name:		Address:		
Pol#	Group #:	Benefit Code:		Effect. Date:
Policy Holder Name:				
SECONDARY INSURANCE				
Name:		Address:		
Pol#	Group #:	Benefit Code:		Effect. Date:
Policy Holder Name:				
Medicaid #:		Medicare:		
ADDITIONAL INSURANCE INFORMATION:				

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE PAYMENT OF SURGICAL/MEDICAL BENEFITS TO SAN ANTONIO PEDIATRIC ASSOCIATES, P.A. FOR SERVICES RENDERED BY A MEMBER OF THE GROUP.AUTHORIZATION TO RELEASE INFORMATION:I HEREBY AUTHORIZA SAN ANTONIO PEDIATRIC ASSOCIATES, P.A. TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS. A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL.I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY SERVICES RENDERED. I HAVE READ ALL THE ABOVE INFORMATION AND HAVE COMPLETED IT. I CERTIFY THAT ALL THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN HEALTH STATUS OR THE ABOVE INFORMATION.

PATIENT'S SIGNATURE (IF APPLICABLE): _____ DATE: _____

PARENT/GUARDIAN'S NAME (PLEASE PRINT): _____

PARENT/GUARDIAN'S SIGNATURE: _____