Pediatric Cardiology Care

Patient ID#: _____

DOV: _____

Staff Initials: _____

NEW PATIENT REGISTRATION

Please complete all fields.

PATIENT INFORMATION

Last name	First name	Middle Init.	DOB	Sex	SSN
			/ /	M F	- -

Address	City	State	Zip Code

Primary Phone	Alternate Phone

Pediatrician/Referring MD	Doctor Phone	Doctor Fax

RESPONSIBLE PARTY

Mother's Last name	Mother's First name	Middle Init.	DOB	SSN
			/ /	- -

Address (if different than above)	City	State	Zip Code

Phone (if different than above)	Alternate Phone	Email

Father's Last name	Father's First Name	Middle Init.	DOB	SSN
			/ /	- -

Address (if different than above)	City	State	Zip Code

Phone (if different than above)	Alternate Phone	Email

Emergency Contact (not living with patient)	**Phone**	**Relationship to Patient**

INSURANCE INFORMATION

Primary Insured Last name	Primary Insured First Name	Primary Insured DOB	Primary Insured SSN
		/ /	- -

Address (if different than above)	City	State	Zip Code

Insurance Company Name/Phone	Member ID Number	Group Number	Relationship to Patient

Insured Employer Name/Address	City	State	Zip Code

I certify to the best of my knowledge that the information above is complete and correct. I authorize the release of any medical information needed by Pediatric Cardiology Care, P.A. to determine my medical reimbursement benefits under my insurance policy. This authorization will remain valid until I revoke it by written notice. I authorize my insurance benefits to be paid directly to Pediatric Cardiology Care, P.A. and understand that submission of claims is not a guarantee of payment, and ultimately I am responsible for any unpaid balance.

Parent/Guardian signature _____ Date: _____