



PATIENT REGISTRATION – Please print clearly

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M / F
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Home Phone: (\_\_\_\_) \_\_\_\_\_ SSN: \_\_\_\_\_ School: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Table with 3 columns: Primary, BILLING INFORMATION, Secondary. Rows include Insurance, Subscriber's Name, Group #, I.D. #, Pts. relationship to subscriber, Billing Type, and Subscriber's employer.

RESERVED FOR PHOTOCOPY SPACE

CONSENT TO TREAT MINORS

I, \_\_\_\_\_, the parent or legal guardian of my child, \_\_\_\_\_,
authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This
authorization will be in effect until revoked in writing by me.

Signature of parent/legal guardian \_\_\_\_\_

EMERGENCY INFORMATION

In case of emergency, local friend or relative to be notified (not living at the same address):

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_
Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

RELEASE OF BENEFITS AND INFORMATION / AGREEMENT TO PAY

I authorize Columbia Pediatrics, P.S. or my insurance company to release any information required to process any claim(s) resulting from services rendered. I authorize my insurance benefits to be
paid directly to Columbia Pediatrics, P.S. I am responsible for any balance due. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_