PATIENT REGISTRATION

Patient Gender: M / F Date of Birth

Patient Gender: M / F Date of Birth

Patient Gender: M / F Date of Birth

Patient Gender: M / F Date of Birth

Address City Zip

Preferred Phone for text appt. confirmation Preferred E-mail

Billing Address [If different from patient's address] City Zip

Parent 1 Full Name SSN# Date of Birth

Parent 1 Employer Cell Phone

Parent 1 Business Phone E-mail

Parent 2 Full Name SSN# Date of Birth

Parent 2 Employer Cell Phone:

Parent 2 Business Phone E-mail

In case of emergency, who should we contact? [Please provide a name other than parent]

Name Telephone

INSURANCE INFORMATION

Insurance Company ID# Group#

Subscriber Effective Date

Secondary Insurance_________________________ ID#_________________________ Group#____

Subscriber__________________________________ Effective Date ________________________

PHARMACY PREFERENCE

Day Pharmacy_____________________________ Phone/Fax/E-mail:_________________________

24 Hr Pharmacy

AUTHORIZATION FOR TREATMENT AND PAYMENT POLICY INCLUDING ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the Doctors and staff of Boulevard Pediatrics to treat the medical condition(s) of my child(ren), and further authorize my signature below for use on any and all insurance claims submitted on our behalf for such services. I hereby irrevocably accept financial responsibility for all medical and related services received while under medical care, and assign any and all insurance benefits otherwise payable by the insurance company for said services. I, the undersigned, understand that I am financially responsible for any and all charges not covered by insurance, and further understand that payment of co-payments an/or deductibles for services received are due at the time services are rendered.

Parent Signature ________________________________

Date ________________________________