

LAKE LEWISVILLE PEDIATRICS, LLP

PATIENT REGISTRATION

**** PLEASE COMPLETE ENTIRE FORM ****

| GENERAL INFORMATION | | | | | | |
|---|----------------------|---------------------------|---------------------------------|-----------------------|---------------------|------------|
| GUARANTOR: | | TITLE (CIRCLE ONE) | | MR. | MRS. | MS. |
| <small>LAST NAME</small> | <small>FIRST</small> | <small>M.I.</small> | | | | |
| STREET ADDRESS: | | | CITY: | ST/ZIP: | | |
| HOME PHONE: | | | WK PHONE: | EXT. | | |
| MOBILE PHONE: | | | DL#: | | | |
| DATE OF BIRTH: | | | EMPLOYER: | OCCUPATION: | | |
| EMAIL ADDRESS: | | | | | | |
| MARITAL STATUS: (CIRCLE ONE) (M) (D) (S) (W) | | | WORK PHONE: | CELL PHONE: | | |
| SPOUSE NAME: | | | | | | |
| **OTHER PARENT | | | LAST NAME | FIRST NAME | MI | |
| HOME PHONE: | | | STREET ADDRESS: | | | |
| MOBILE PHONE: | | | CITY: | ST/ZIP: | | |
| WORK PHONE: | | | SS#: | DATE OF BIRTH: | | |
| ALL CHILDREN THAT MAY VISIT OUR OFFICE: | | | | | | |
| PATIENTS NAME: | | D.O.B: | | M/F | PCP SELECTED | |
| <small>LAST</small> | <small>FIRST</small> | <small>MI</small> | | | | |
| SIBLINGS NAME: | | D.O.B: | | M/F | PCP SELECTED | |
| <small>LAST</small> | <small>FIRST</small> | <small>MI</small> | | | | |
| SIBLINGS NAME: | | D.O.B: | | M/F | PCP SELECTED | |
| <small>LAST</small> | <small>FIRST</small> | <small>MI</small> | | | | |
| SIBLINGS NAME: | | D.O.B: | | M/F | PCP SELECTED | |
| <small>LAST</small> | <small>FIRST</small> | <small>MI</small> | | | | |
| SIBLINGS NAME: | | D.O.B: | | M/F | PCP SELECTED | |
| <small>LAST</small> | <small>FIRST</small> | <small>MI</small> | | | | |
| INSURANCE INFORMATION | | | | | | |
| PRIMARY INSURANCE CARRIER: | | | POLICY ID #: | GROUP #: | | |
| NAME OF INSURED IF DIFFERENT FROM GUARANTOR: | | | | | | |
| OTHER PERSONS AUTHORIZED TO SEEK SICK CARE: | | | RELATIONSHIP TO PATIENT: | | | |
| | | | | | | |
| | | | | | | |

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes release of any information relating to claims for benefits submitted on behalf of myself and/or dependents. I further express and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. Any copy of this document is as valid as the original.

I, _____, hereby authorize _____
 (PRINT NAME OF INSURED) (PRINT NAME OF INSURANCE COMPANY)
 to pay and hereby assign directly to LAKE LEWISVILLE PEDIATRICS all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to LAKE LEWISVILLE PEDIATRICS will be credited to my account, in accordance with above said assignment.

X _____
 (AUTHORIZING SIGNATURE / PARENT OR GUARDIAN)

 (DATE)