

DR. MO *PEDIATRIC CENTER*

REGISTRATION FORM

(Please Print)

Today's date:				For Office Use: Records Code			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Food/Drug Allergies:	
Nick Name:		Birth date:					
<input type="checkbox"/> Yes <input type="checkbox"/> No				/ /		<input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home phone no.:		
					()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.:		
					()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.:	
		/ /				()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.:	
						()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Welfare <i>(Please provide coupon)</i>	<input type="checkbox"/> Other			
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:		Policy no.:	Co-payment:
			/ /				\$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:
			()	()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.				

Patient/Guardian signature

Date