PEDIATRICS OF AKRON, INC. PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name:_____ Date Of Birth:____/____/____
Last First Middle

Patient Address:_____ Gender: Male___ Female___
Number & Street Apt. # City State Zip

Patient Telephone: (____)_____ Child Lives With: ( ) Mother ( ) Father ( ) Both

PARENTS & LEGAL GUARDIANS

PARENT/LEGAL GUARDIAN 1:

Name:_____ Date of Birth:____/____/____
Last First Middle

Address:_____ SS#____/____/____
Number & Street Apt. # City State Zip

Home Phone: (____)_____ Cell/Mobile Phone: (____)_____

Employer:_____ Employer Phone: (____)_____

Relationship to Patient: ___Biological Parent ___Adoptive Parent ___Foster Parent ___Step-Parent

Marital Status: ____Married ____Widowed ____Divorced ____Single Gender: Male____ Female____

Name of Spouse: _____
Last First Middle

PARENT/LEGAL GUARDIAN 2:

Name:_____ Date of Birth:____/____/____
Last First Middle

Address:_____ SS#____/____/____
Number & Street Apt. # City State Zip

Home Phone: (____)_____ Cell/Mobile Phone: (____)_____

Employer:_____ Employer Phone: (____)_____

Relationship to Patient: ___Biological Parent ___Adoptive Parent ___Foster Parent ___Step-Parent

Marital Status: ____Married ____Widowed ____Divorced ____Single Gender: Male____ Female____

Name of Spouse: _____
Last First Middle

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Insurance:_____ Subscriber Name:_____
Last First M

SECONDARY INSURANCE:

Name of Insurance:_____ Subscriber Name:_____
Last First M

Every minor child seen in our office for medical services MUST be accompanied by a parent, legal guardian or adult who knows the child's medical history and can give permission for necessary treatment or tests. Pediatrics of Akron will assume that anyone bringing your child in for medical treatment has your permission to do so. As such, we will not hesitate to treat your child.
We may leave messages on your answering machine regarding appointments or other issues. If this is NOT how you wish to proceed with medical treatment of your child, YOU must notify us in WRITING.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Pediatrics of Akron, Inc. to release to my insurance company, managed care organization, state agencies, federal agencies, Medicaid, Medicare, third party administrators any information needed to process any claims and/or determine benefits payable for related services. I also authorize Pediatrics of Akron, Inc. to utilize a fax machine to transmit any or all of the above medical records pertaining to my child/children's medical care for insurance reimbursement. I acknowledge that faxing medical records may increase the risk of accidental disclosure of these records. I grant permission to Pediatrics of Akron, Inc. to release all or part of my child/children's medical records to any consulting entity that may be involved in their care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicaid, Medicare, managed care organization, third party administrators, commercial, liability and/or another insurance benefits be made to Pediatrics of Akron, Inc. for services furnished to my child/children or on their behalf by that provider.
I have also read, understand and have agreed to the financial policy of Pediatrics of Akron, Inc.

By signing below I verify that all of the above information is complete and correct, that I have legal authority to authorize medical treatment for the patient, and that I authorize payment to be made to Pediatrics of Akron, Inc. by my insurance carrier.

Signature_____ Date_____

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