integrapy
MAKING THE CONNECTION

CHILD PATIENT REGISTRATION FORM

(Please Print Clearly)

Today's Date:_____

CLIENT INFORMATION

Last Name: _____First: _____ Middle: _____ Male Female

Address:_____Apt#:_____ Birth date: _____Age: _____

City:_____State:_____Zip:_____ Birth Place:_____

Home Phone:_____Social Security no.:_____

School:_____Grade:_____

Is student living with both natural parents? Yes No If no, please explain: (Adoption, divorce, death, etc.)

Present Mother_____

Address (If different from child): _____

_____Apt#:_____

City:_____State:_____Zip:_____

Phone: (H)_____(C)_____

Social Security #:_____

Are you employed? Yes No

Occupation:_____

Who referred you to our office?_____

Present Father_____

Address (If different from child): _____

_____Apt#:_____

City:_____State:_____Zip:_____

Phone: (H)_____(C)_____

Social Security #:_____

Are you employed? Yes No

Occupation:_____

Who is financially responsible for this bill?_____

I will be paying today by: Cash Cheque Credit Card Debit Card

integrapy
MAKING THE CONNECTION

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:_____Birth date:_____

Address (if different):_____Phone (H): _____

Is this person a patient here? Yes No Occupation:_____Employer:_____

Employer address:_____Phone (B): _____

Is this patient covered by insurance? Yes No

Please indicate primary insurance: Insurance Welfare (Please provide coupon) Other

Subscriber's name:_____Subscriber's S.S. no.:_____

Birth date:_____Group no.:_____Policy no.:_____Co-payment: $_____

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable):_____

Subscriber's name:_____Group no.:_____Policy no.:_____

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):_____

Relationship to patient:_____Phone: (H)_____(B)_____

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.

PRINTED NAME | PARENT/LEGAL GUARDIAN SIGNATURE | DATE