

# PATIENT REGISTRATION 2012

DATE: \_\_\_\_\_

CHART # / OFFICE: \_\_\_\_\_

1. PATIENT'S NAME: \_\_\_\_\_  
LAST FIRST MI DATE OF BIRTH SEX

2. PATIENT'S NAME: \_\_\_\_\_  
LAST FIRST MI DATE OF BIRTH SEX

3. PATIENT'S NAME: \_\_\_\_\_  
LAST FIRST MI DATE OF BIRTH SEX

CHILD LIVES WITH: \_\_\_\_\_ BOTH PARENTS \_\_\_\_\_ MOTHER \_\_\_\_\_ FATHER OTHER, PLEASE SPECIFY \_\_\_\_\_

## PRESENT INSURANCE CARD

POLICY HOLDER NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
LAST FIRST MI

HOME ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE ZIP CODE

HOME # \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
LAST FIRST MI

HOME ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE ZIP CODE

HOME # \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
LAST FIRST MI

HOME ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE ZIP CODE

HOME # \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

## NAME OF PERSON BRINGING CHILD IN

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

I here by assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans to: Pediatric Associates of Orlando. This assignment will stay in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original; I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.