

# CHILD

## PEDIATRIC AND ADOLESCENT REGISTRATION FORM

Use this form if you are registering your child



### PATIENT INFORMATION

First Name	Last Name	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address	City	State	Zip
Date of Birth	Age	Social Security Number	

### PARENT INFORMATION

#### *Parent With Whom Child Lives*

#### *Other Parent (Biological)*

Name			Name		
Address			Address		
City	State	Zip	City	State	Zip
Day Phone			Day Phone		
Cell Phone			Cell Phone		
Employer Name			Employer Name		
Employer Number			Employer Number		

### Emergency Contacts

Name	Relationship	Phone
Name	Relationship	Phone
Whom May We Discuss Your Child's Medical Information With?		<input type="checkbox"/> Myself Only <input type="checkbox"/> Other

### INSURANCE INFORMATION

#### *Primary Insurance*

Insured Name	DOB	SSN
Company Name	Policy / ID Number	
Address	Group Number	
City	State	Zip

#### *Secondary Insurance*

Insured Name	DOB	SSN
Company Name	Policy / ID Number	
Address	Group Number	
City	State	Zip

#### HEALTH INSURANCE CLAIMS SUBMISSION POLICY

Your insurance is a method for you to receive reimbursement for fees you have paid to our physicians for their services. Having insurance is not a substitute for payment. Many carriers have fixed allowances or percentages based on your contract with them, not with our office. If we participate with your insurance, we will accept the fees we have pre-negotiated with them. It is your responsibility to pay deductible, co-insurance, copays, and non-covered balances.

#### RELEASE AND ASSIGNMENT

I hereby authorize Lifeboat Medical Associates to apply for benefits on my behalf for services rendered each time my child(ren) presents for care. Further, I assign payments from my insurance carrier to Lifeboat Medical Associates for medical services rendered. I understand I am responsible for any amount non-covered by my insurance.

Parent's Signature

Date