

MINOR PATIENT REGISTRATION FORM

Child's Name: _____
Last First M.I.

Date of Birth: ___/___/___ Age: _____ Sex: Male Female

Last 4 digits of child's SSN: _____

Home Address: _____
Street # Street Name Apt #

City State Zip

Legal Guardian or
Parent Name: _____ Date of Birth: ___/___/___
Last First M.I.

Home Phone: () _____ Cell Phone: () _____

Email Address: _____ Last 4 digits of your SSN: _____

INSURANCE COVERAGE – PRIMARY:

Insurance Co. Name: _____

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ___/___/___

INSURANCE COVERAGE – SECONDARY:

Insurance Co. Name: _____

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ___/___/___

Who is your in-network Laboratory? _____

FINANCIAL POLICY:

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service (e.g., deductibles, copayments, and non-covered services.)

Patient relationship to policy owner: Self Child Other: _____

Policy owner place of employment _____

I understand a parent must accompany child to every appointment.

Signature of Parent/Legal Guardian

___/___/___
Date

Please present insurance card(s) and photo ID to the receptionist so copies may be made.