Stockbridge Pediatrics, P.C.

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential. Also, please provide the receptionist a picture id and your insurance card

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone: Cell Phone:	Patient's Social Security #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/_____	Responsible Party's Social Security #
Responsible Party Drivers License # State:		Occupation	How Long at current Employer?
E-MAIL ADDRESS:			
Name of employer Address		Business Phone	Occupation
Name of Spouse/Parent	Birth date	Social security #	Business phone
Reason for Visit:	Referred by: (include address and phone)	How did you hear about us?	
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicaid	Yes [ ] No [ ]	Medicaid #	Effective Date	

Primary insurance company Address			Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #	Group #
Secondary insurance name Address		Policy #	Group #

Medicaid Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Stockbridge Pediatrics, P.C. for any services furnished me by the physician and/or other licensed medical provider. I authorize any holder of medical information about me to release to the Centers for Medicaid Services and its agents any information to determine these benefits payable for related services

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Stockbridge Pediatrics, P.C. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for medical benefits.

_____ _____
Patient, Parent or Guardian Signature Date