BLACK ROCK PEDIATRICS

REGISTRATION FORM

Today's Date:					
PATIENT INFORMATION					
Patient Name(s):			Date of Birth:	Age:	Sex:
					❑ M ❑ F
					❑ M ❑ F
					❑ M ❑ F
					❑ M ❑ F
					❑ M ❑ F
Parent's Names: Home Telephone:		Mother's Cell Phone: Father's Cell Phone:		Mother's Work Phone: Father's Work Phone:	
Street Address:		City:		State/Zip Code:	
Email Address:					

INSURANCE INFORMATION		
Insurance Carrier:	ID Number:	
Policy holder's name:	Policy holder's DOB:	Policy holder's S.S. #:
Well Visit Co-pay:	Sick Visit Co-pay:	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship:	Home Telephone:	Work Telephone:

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 Black Rock Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*