REGISTRATION FORM
HOSPITAL DRIVE PEDIATRICS

Patient's Name _____ ☐M ☐F DOB _____

Do you have other children who come here? Names & birth dates: _____

_____

How were you referred to our office? Dr._____ ☐Health Plan

☐Internet_____ ☐Friend/Family_____ ☐Other_____

PARENTS are ☐Married ☐Civil Union ☐Divorced ☐Separated ☐Widowed ☐Never Married

Parent's Name_____ Soc Sec#_____ DOB _____

Street Address_____Apt#_____

City_____ State_____ Zip_____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Best time to reach you _____ *Please circle best phone number*

Occupation_____ Employer _____

If parents are not married: This parent has: ☐Legal custody (☐sole ☐joint) ☐Physical custody (☐sole ☐joint)

Parent's Name_____ Soc Sec#_____ DOB _____

Street Address ☐Same _____Apt#_____

City_____ State_____ Zip_____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Best time to reach you _____ *Please circle best phone number*

Occupation_____ Employer _____

If parents are not married: This parent has: ☐Legal custody (☐sole ☐joint) ☐Physical custody (☐sole ☐joint)

EMERGENCY CONTACT

Name_____ Relationship _____

Street Address _____Apt#_____

City_____ State_____ Zip_____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

INSURANCE: (please give us current card to copy)

Insured Person_____ Insurance_____

SECONDARY INSURANCE: (please give us current card to copy)

Insured Person_____ Insurance_____

I AUTHORIZE HOSPITAL DRIVE PEDIATRICS TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR MY CHILD/CHILDREN AND REQUEST THAT THE INSURANCE COMPANY MAKE PAYMENT DIRECTLY TO HOSPITAL DRIVE PEDIATRICS. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES RECEIVED BY MY CHILD/CHILDREN, REGARDLESS OF WHETHER THESE SERVICES ARE COVERED BY MY HEALTH PLAN. ALL COPAYS ARE DUE AT TIME OF SERVICE REGARDLESS OF WHO BRINGS MY CHILD IN.

Signature_____ Date_____