Welcome to our Practice

New Patient Registration

Patient Name______________________________DOB___________________Male___Female__

Home Address____

City, State, Zip_________________________________ Home Phone_________________________

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Mother/Legal Guardian: Name______________________________DOB___________________

SS#____________________ Employer___________________Occupation______________________

Home Phone________________Work Phone_____________________Cell#___________________

Email Address____

Father/Legal Guardian: Name________________________________DOB__________________

SS#____________________ Employer___________________Occupation______________________

Home Phone________________Work Phone_____________________Cell#_____________________

Email Address____

Child lives with: Mother________Father________Both_________Guardian__________

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Preferred Pharmacy Name_________________________________City___________________

Phone#_________________________________ Fax#____________________________________

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Financially Responsible Party (Guarantor) Self____Spouse___Parent____Other______

Name________________________________DOB__________SS#___________________

Address_________________________________City, State, Zip_______________________

Home Phone______________Cell #________________Work #______________________

Employer____

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Policy Holder Information Self________ Spouse_______Parent________Other_______

*If same as responsible party, check here_____

Name______________________________DOB____________SS#________________

Address__________________________________City, State, Zip___________________

Home Phone________________Cell#___________________Work#________________

Employer____________________________Insurance Company_____________________

*Please provide a copy of your insurance card

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CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

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PATIENT, PARENT, LEGAL GUARDIAN DATE

INSURANCE ASSIGNMENT

I hereby authorize my insurance company benefits to be paid directly to Family First Pediatrics. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

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PATIENT, PARENT, LEGAL GUARDIAN DATE