Belliaminowa V. Jackson M.D. Pediatric Office Patient Registration Form

Patient's Last Name: _____ First Name: _____ M.I. _____
(Apellido del Paciente) (Nombre del Paciente) (Incial del 2do Nombre del Paciente)

Birth Date: – – Age: ____ Sex: ☐ Male ☐ Female Social Security No.: / /
(Fecha de Nacimiento) (Edad) (Sexo) (Masculino) (Femenino) (Numero de Seguro Social)

Street Address: _____ City: _____ State_____: ZIP: _____

Home Phone No.: – ( )

PARENT(S) / LEGAL GUARDIAN INFORMATION

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

Birth Date: – – Social Security No.: / /

Street Address: _____ City: _____ State_____: ZIP: _____

Home Phone No.: ( ) –

Work Phone No.: ( ) –

Cell Phone No.: ( ) –

Occupation: _____ Employer: _____

Employer's Address: _____

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

Birth Date: – – Social Security No.: / /

Street Address: _____ City: _____ State_____: ZIP: _____

Home Phone No.: ( ) –

Work Phone No.: ( ) –

Cell Phone No.: ( ) –

Occupation: _____ Employer: _____

Employer's Address: _____

INSURANCE INFORMATION

Is patient covered by insurance? ____ Yes ____No

Person responsible for bill: _____ Please give insurance card to the Receptionist for copying

Mother's Insurance

Company: _____ Insurance Address: _____

Insurance Phone No.: ( ) –

Is patient covered by this policy? _____ Yes _____ No

Policy Number: _____ Group or Plan Number: _____ Co-Payment: $_____ Deductible: $_____

Effective Date: _____/_____/_____

Father's Insurance

Company: _____ Insurance Address: _____

Insurance Phone No.: ( ) –

Is patient covered by this policy? _____ Yes _____ No

Policy Number: _____ Group or Plan Number: _____ Co-Payment: $_____ Deductible: $_____

Effective Date: _____/_____/_____

IN CASE OF EMERGENCY

Name of friend / relative (not living at same address): _____ Relationship to patient: _____

Work Phone No.: ( ) – Cell Phone No.: ( ) –

CONSENT

The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to **Belliaminowa V. Jackson M.D.** I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Group and/or the insurance company to release any information required to process my claim.

I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

Patient / Guardian: _____

Signature: _____ Date: _____