PATIENT REGISTRATION FORM

Today's Date:_____

Primary Care Physician: ___Elliott ___Gorin ___Kelly ___Willenborg ___Maduka ___Dragoi

Name of Patient:_____ Date of Birth: _____
Last Name First Name Middle

____Male ____Female SS#_____

Address (mailing) _____

City _____ State _____ Zip_____

Home Phone: _____ Secondary Phone: _____

Patient lives with: ___Mother ___Father ___Both ___Other_____

Responsible Party Information

Name: _____Date of Birth:_____ SS# _____

Address (if different from patient) _____

Employer: _____ Work Phone: _____

Address _____

City _____ State _____ Zip_____

Primary Insurance Information

Policy Holder Name: _____ Date of Birth: _____ SS#_____

Relationship to patient: _____

Insurance Company: _____

Insurance Address: _____

City _____ State _____ Zip_____

Policy # _____ Group # _____ID #_____

___State Pending ___Managed Care ___Issue Date _____ Medicaid # _____

Secondary Insurance Information

Policy Holder Name: _____ Date of Birth: _____ SS#_____

Relationship to patient: _____

Insurance Company: _____

Insurance Address: _____

City _____ State _____ Zip_____

Policy # _____ Group # _____ID #_____

Siblings

Name: _____Date of Birth:_____

Name: _____Date of Birth:_____

Name: _____Date of Birth:_____

Assignment of Benefits Release

I, the undersigned, have insurance coverage with _____and assign directly to Mansfield Pediatrics, L.L.C. Medical Benefits, if any, otherwise payable to me for services rendered. I understand that my medical coverage is a contract between me and the insurance carrier. If for any reason your insurance denies coverage you at totally responsible for any and all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Signature: _____ Date: _____