REGISTRATION INFORMATION
Pediatrics

Date______________

Patient Name (Last, First, MI):____

Telephone (Home):_______________________ Telephone (Cell):_____________________________

Street Address:____

City:____ State:___________ Zip Code:_______________

Birthdate:____/____/_____ Age:______ Sex M F Social Security Number__________________

Parents Names:____

Employer:____ Telephone Number:___________________

Business Address:____

Occupation:__________________________________ Social Security Number (Mother):_______________

Birthdate (mother):____/____/_____ Birthdate (Father):____/____/_____ SS# (Father):__________________

Emergency Contact:_____________________________________ Phone #'s:__________________________

Your Drug Store Name:___________________________________ Phone:______________________________

How did you hear of our practice?____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I, ____, hereby authorize

____ (Ins. Co.) to pay and hereby assign directly to Better Health Medical Center, Inc. all benefits, if any, otherwise payable to me for services as described above. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Better Health Medical Center, Inc. will be credited to my account, in accordance with the above assignment.

I agree by signing below that I will schedule follow-up and well child check appointments as deemed necessary by my physician. I also agree should the need arise to reschedule or cancel said appointments I will give at least a 24 hour notice or I may incur a $25.00 missed appointment fee.

____ ____________________

Parent/Legal Guardian Date

Copyright Better Health Medical Center, Inc.