Pinecone Pediatrics Patient Registration
(**PLEASE PRINT CLEARLY**)

Patient's Legal Name: _____ _____
Last First Middle

Address: _____
Street Apt. #

_____
City State Zip

Date of Birth (Mo./Day/Year): _____ Age: _____ Sex (circle): M F

Best contact #: (_____)_____ Cell #: (_____)_____ Home #: (____)_____

Email: _____ Referred by: _____

Parent/Legal Guardian: _____	Parent/Legal Guardian: _____
Relationship to patient: _____	Relationship to patient: _____
Address (if different): _____	Address (if different): _____
Birthdate: _____	Birthdate: _____
Employer: _____ SS#:_____	Employer: _____ SS#:_____
Preferred Contact #: _____	Preferred Contact #: _____
Consent to leave message: YES/NO	Consent to leave message: YES/NO

Parents Marital Status: Married/Divorced/Single/Widowed/Other _____

Insurance Information

Primary Insurance Carrier: _____

Member ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to Patient : _____

Secondary Insurance Carrier: _____

Member ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to Patient : _____

- Insurance Disclaimer: I understand that it is my responsibility to provide all insurance information to Pinecone Pediatrics for proper billing. If any insurance information is withheld including any other insurance for the patient, I understand that I will be financially responsible for charges incurred during this time. **Initials _____**

- Secondary Coverage: I understand that is it my responsibility to disclose any other coverage that may be in addition to the primary coverage and have contacted both insurance companies regarding the other insurance policy**. I agree that I have completed coordination of benefits with both coverages to determine which coverage is designated as primary and secondary based on the insurance rules.** Failure to do so may result in claim denials and/or rejections and incurred charges will be my responsibility to pay. **Initials _____**

I agree that the above is true and correct to the best of my knowledge. I understand that the office policy is that the parent who requests treatment for the child is responsible for the costs associated with services rendered. I acknowledge that I have read and agree to the Pinecone Pediatrics Statement of Financial Responsibility.

Print Name (Parent): _____ Relationship to Above Patient: _____

Signature of Parent: _____ Date: _____