RIVERSIDE PEDIATRICS, P.A.

Date: _____

PATIENT REGISTRATION (Please print LEGIBLY and fill out ALL fields)

Patient Name: First _____ Middle _____ Last _____

Address: _____ City: _____ State: ____ Zip: _____

Patient Date of Birth: _____/_____/_____ Sex: _____ Nickname: _____

Brothers & Sisters

NAME: _____ DOB: _____ NAME: _____ DOB: _____

NAME: _____ DOB: _____ NAME: _____ DOB: _____

Parent #1 (POLICY HOLDER) MOM OR DAD (Circle one)

Name: First _____ MI _____ Last _____

Address (IF different than patient) _____

DOB: _____/_____/_____ Social Security #: _____

Cell #: _____ Work #: _____

Employer Name: _____ Occupation: _____

EMAIL Address: _____

Parent #2 MOM OR DAD OR ALTERNATE PARENT (Circle one)

Name: First _____ MI _____ Last _____

Address (IF different than patient) _____

DOB: _____/_____/_____ Social Security #: _____

Cell #: _____ Work #: _____

Employer Name: _____ Occupation: _____

EMAIL Address: _____

PLEASE CIRCLE ONE OPTION PER ROW:

Email/Text appointment confirmations: Parent #1 or Parent #2

Billing Statements: Parent #1 or Parent #2

SEE OTHER SIDE →→→

CONSENT & AUTHORIZATION AGREEMENT

Consent or Treatment:

I acknowledge that medical examination and treatment may be required for the patient as determined by a healthcare provider. I hereby give my consent and authorize the performance of any diagnostic and therapeutic procedures considered appropriate or necessary, including those required in an emergency situation.

Assignment of Benefits:

For patients with accepted insurance, I authorize my insurance benefits to be paid directly to the provider. I understand that I am responsible for any services not covered by my insurance plan.

Release of Information:

I hereby authorize the provider to release any medical information necessary to process claim forms or to assist in medical testing and treatment.

Agreement to Pay Services:

I understand and agree that I am responsible for paying all charges associated with the services provided to the patient listed on this registration.

Fees:

I understand there will be charges for the following:

- Returned checks - $35
- Failure to appear for a scheduled appointment or to provide a minimum of 24 hours' notice of cancellation - $50
- Billing or copays due at the time of service
- Claims resubmission

(Parent or Guardian must sign if patient is a minor)

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____/_____/_____