

Watoto Pediatric & Adolescent Specialty, LLC

PATIENT REGISTRATION

Child's First Name	Last Name	Birthday	Sex	Nickname

Mother's Name _____

Date of Birth ____/____/____ SS# ____-____-____

Home Address _____ City _____ Zip _____

Home Phone (____)____-____ Cell Phone (____)____-____ Email _____

Occupation _____ Place of Employment _____

Work Phone (____)____-____ Ext _____ Single [] Married [] Divorced [] Widowed []

Father's Name _____

Date of Birth ____/____/____ SS# ____-____-____

Home Address _____ City _____ Zip _____

Home Phone (____)____-____ Cell Phone (____)____-____ Email _____

Occupation _____ Place of Employment _____

Work Phone (____)____-____ Ext _____ Single [] Married [] Divorced [] Widowed []

Emergency Contact: Name: _____ Relation _____ Phone _____

Legal Guardian: Name: _____ Relation _____ Phone _____

I authorize the individuals listed below to be involved in my children's medical treatment, including bringing them in for visits:

Name and Relationship

Name and Relationship

Parent or Legal Guardian Signature

Insurance Information (Please give your insurance card(s) and Photo ID to the receptionist):

Primary Insurance Company's Name _____

Policy Holder's Name _____

Member ID# _____ Group # _____

Secondary Insurance Company's Name _____

Policy Holder's Name _____

Member ID# _____ Group # _____

Insurance Assignment and Releases

I, the undersigned hereby assign, transfer and set over to Watoto Pediatric & Adolescent Specialty all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for me by Watoto Pediatric & Adolescent Specialty and I direct my insurance company to pay any and all such entitlements directly to Watoto Pediatric & Adolescent Specialty.

Parent or Legal Guardian Responsible for Account

Date

I authorize Watoto Pediatric & Adolescent Specialty to render medical care to my child. **I understand that all co-pays and deductibles are to be paid at the time of service.** In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I agree to pay any and all costs of collection including attorney's fees. In the event that my child is hospitalized, I authorize the release of any medical information necessary to process an insurance claim and I authorize payment of medical benefits directly to Watoto Pediatric & Adolescent Specialty. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy. I will assist in the collection of my insurance benefit should there be any delay in payment. I have received the attached "Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law.

I have received the attached "Office Policies and Procedures" and agree to its terms.

Parent or Legal Guardian Signature

Date

Whom may we thank for referring you? _____